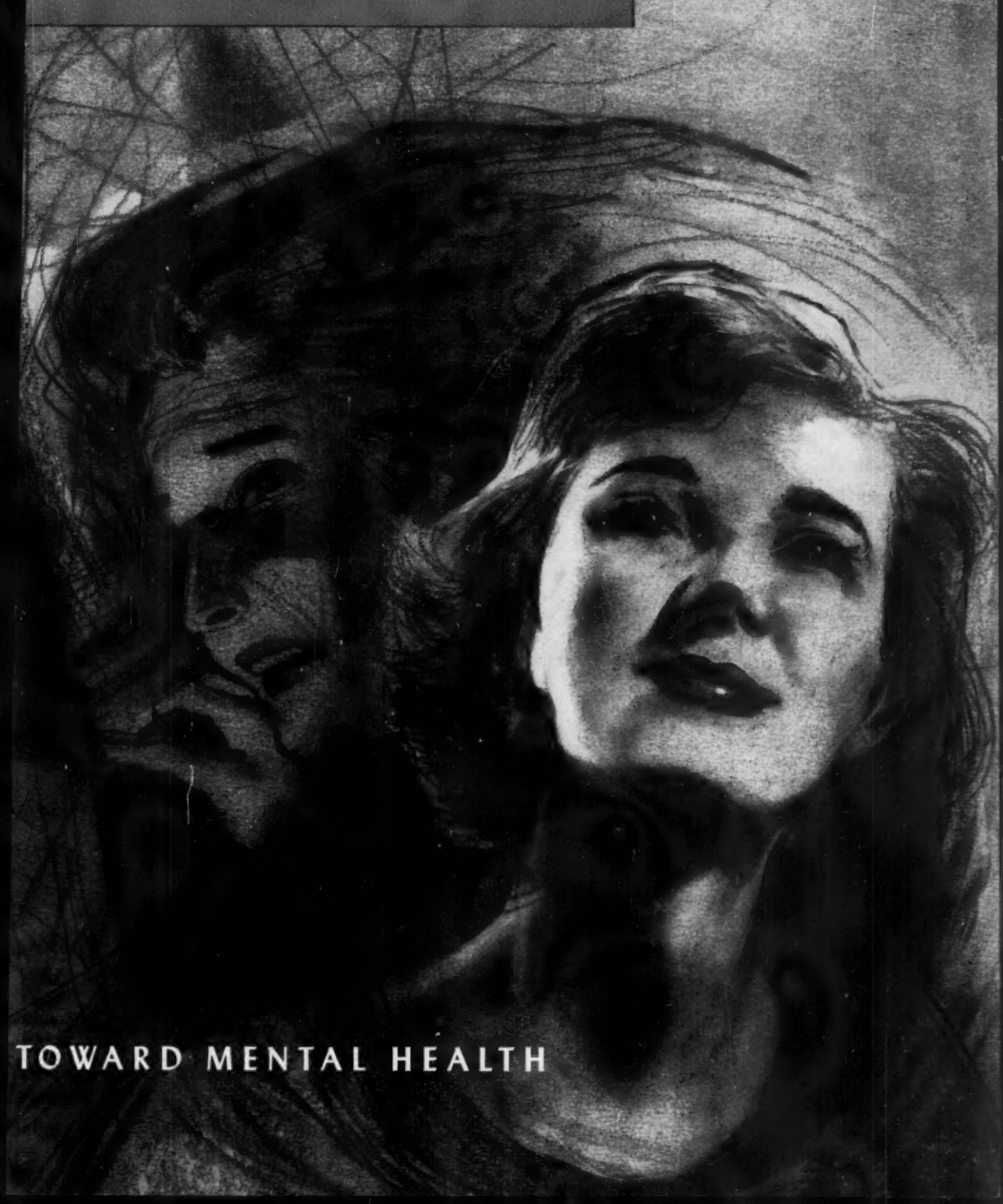
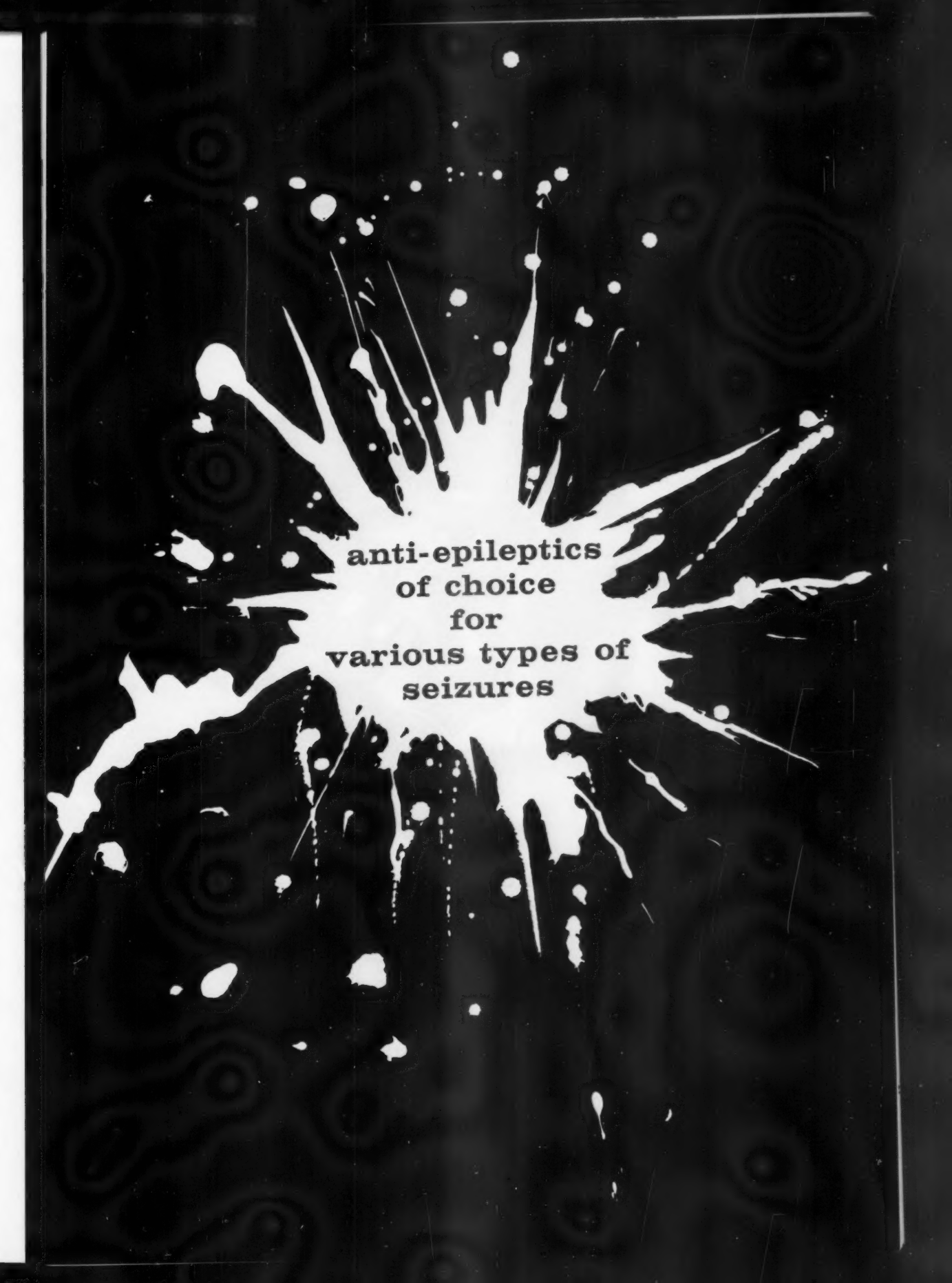
The Journal
Michigan
STATE MEDICAL SOCIETY

October, 1957
Volume 56
Number 10



TOWARD MENTAL HEALTH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THE JOURNAL
of the Michigan State Medical Society

VOLUME 56 OCTOBER, 1957 NUMBER 10

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THE JOURNAL
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VOLUME 56 OCTOBER, 1957 NUMBER 10

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Roerig

New York 17, New York

1. Russek, H. I.: J. Am. Geriat. Soc. 4:877 (Sept.) 1956.

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You and Your Business

"REFRESHERS" ARE DEDUCTIBLE

The U. S. Internal Revenue service regulation (effective August 9, 1956) makes deductible expenditures for education for a "refresher" course, or similar type of course taken to maintain the skills directly and immediately required by the physician in his employment or business. Such a course must be of short duration, not to be taken on a continued basis, and not carry academic credit.

When a doctor of medicine travels away from home primarily to obtain "refresher" education, his expenditures for travel, meals, and lodging while away from home are deductible.

The Michigan Clinical Institute (Detroit, March 19-20-21, 1958) and the Michigan State Medical Society Annual Session (Detroit, October 1-2-3, 1958) are "refresher" courses.

FEE-SPLITTING LAW OF THE STATE OF MICHIGAN

Section 338.53 of the Compiled Laws of 1948 as amended by Act No. 54 of the Public Acts of 1954:

"Sixth. The board of registration of medicine may refuse to issue or continue a certificate of registration or license provided for in this section to any person guilty of grossly unprofessional and dishonest conduct. The words 'unprofessional and dishonest conduct,' as used in this act, are hereby declared to mean:

". . .

"(h) Employing or being employed by any capper, solicitor or drummer for the purpose of securing patients; or subsidizing any hotel or boarding house with a like purpose, or paying, or offering to any person, money or any other thing of value with a like purpose, or advertising to do so in any form whatsoever; or the division of fees in a consultation or a reference of a patient to a specialist, when no actual professional service is rendered by the physician referring the case, without the knowledge of the patient or the person concerned in the payment thereof."

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of August 14, 1957

- **Opinion Study of Prepaid Medical Care Coverage in Michigan.**—Up-to-the-minute progress report was presented. The sub-titles of the survey are to be (a) "Prepaid Medical Care Coverage and Related Costs Survey," (b) Survey of Consumer Opinion on Medical Care Protection," (c) "Doctor Opinion Survey on Prepaid Medical Care Plans," (d) "Survey of Related Studies on Protection Against Medical Service Fees."

  Letters of appreciation were authorized sent to the *Lansing State Journal,* the *Detroit Times* and to Mr. Jack Pickering for cooperation in the publishing this survey.

- **Beaumont Memorial.**—The Michigan Mackinac Island State Park Commission, on July 13, approved the agreement between MSMS and the Commission, whereby the ownership of the personal property in the Beaumont Memorial has been transferred to MSMS. (This ageement was approved by MSMS July 12, 1957.)

  A. H. Whittaker, M.D., of Detroit, recently appointed by Governor G. Mennen Williams as a member of the Mackinac Island State Park Commission, was fittingly congratulated on this signal honor.

- **President-Elect G. W. Slagle, M.D.,** made additional appointments to 1957-58 MSMS Committees.

- **1957 Annual Session.**—Various details connected with the Annual Session, Grand Rapids, September 25-26-27 were decided.

- **Use of the MSMS addressograph** was authorized for Blue Cross (Michigan Hospital Service) to facilitate its mailing a letter in connection with creation of review committees in all hospitals as part of the continuing control program in Blue Cross cases.

- **Group Life Insurance program for MSMS Members.**—Progress report of survey, to August 12, 1957, indicated that 2,242 cards have been returned by MSMS members, with 1,395 indicating interest in a group life insurance program.

- **Co-sponsorship** by MSMS of a Seminar on "The Epidemiology, Bacteriology, and Therapy of Staphylococcus Infections in Hospitals," Lansing Civic Center, September 19, was approved.

- **Legal Counsel** reported a reactivation of hospital litigation in Oakland County (MSMS is not a party in this suit).

  Legal Counsel also stated that he was in the process of developing a non-profit, tax-exempt corporation to be known as the "Beaumont Memorial Foundation," as per instruction of the MSMS House of Delegates. The Executive Committee instructed that the members of the Beaumont Memorial Committee be listed as incorporators of the Beaumont Memorial Foundation.

- **History of Michigan Medical Service.**—Commenting on a recent historical item received

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(Continued from Page 1208)

from Frederick A. Baker, M.D., of Pontiac, the Executive Committee of The Council, upon suggestion of L. Fernald Foster, M.D., President of Michigan Medical Service, authorized Editor Wilfrid Haughey and John B. Kantner (Michigan Health Council) to write an historical record of Michigan Medical Service.

- **Practice of Medicine by a Corporation.**—MSMS objection to the Michigan Hospital Service proposal to offer *medical* service to its subscribers, was discussed; The Executive Committee of The Council reaffirmed its action as expressed in its August 2nd letter of protest to Blue Cross, and authorized Legal Counsel to proceed with any necessary legal action that is feasible if out-patient (i.e., medical) care is added to contracts of Blue Cross.

- **H. Waldo Bird, M.D.,** of Ann Arbor, and **G. Thomas McKean, M.D.,** of Detroit, were added to the Committee on VA Hometown Medical Care Program, at the recommendation of Committee Chairman Wm. Bromme, M.D., of Detroit.

- **B. L. Masters, M.D.,** Chairman of MSMS Rural Medical Service Committee, was authorized to attend Rural Health Institute (sponsored by the AMA) at Purdue University, October 4-5.

- **E. H. Wiard,** long-time Executive Secretary of the Michigan Health Council, resigned as of September 1 to enter business. A letter of commendation for his significant contribution to the growth of Michigan Health Council was authorized sent to Mr. Wiard.

- **Committee Reports Presented.**—(1) Arbitration Committee, meeting July 12; (2) Committee on National Defense, July 17; (3) Scientific Radio Committee, July 17; (4) Legislative Committee, July 18; (5) Venereal Disease Control Committee, July 18; (6) Committee on Course in Medical Economics and Ethics, August 6; (7) Permanent Advisory Committee on Fees, August 7; (8) Public Relations Committee, August 11.

TWO DECADES OF HEALTH SERVICE PRICES REVIEWED

A featured special article in current (Sept.) issue of *Monthly Labor Review* is an informative review of the ups and downs in consumer prices for medical care and hospital services between 1936 and 1956. Using the years 1947-49 as a base, the price index for medical care at close of 1956 was highest of all major items (housing, clothing, etc.), just as it is today. But this article points out that if hospitalization is stripped out of medical care, the price increase for this item between 1936 and 1956 actually is the *smallest of all.*

In this 20-year period, hospital room rates went up 264.8 per cent, which explains why the medical care index has risen so much. At the same time, however, surgeons' fees have gone up only 59.5 per cent, general practitioners' fees 72.8 per cent and dentists' fees 82.1 per cent. This compares with a 220.9 per cent rise for haircuts, 135.0 for shoe repairs and 112.9 for public transportation. —WRMS, October 7, 1957.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by country medical societies and other physician groups in Michigan, follows:

1957		
Autumn	MSMS Postgraduate Extramural Courses	Statewide
Oct. 24-25	Michigan Cancer Conference	East Lansing
Nov. 6-7	Michigan Academy of General Practice—11th Annual Fall Postgraduate Clinic	Detroit
Dec. 3-6	AMA Clinical Session	Philadelphia
1958		
Jan. 22-24	11th Annual Michigan Rural Health Conference	Ann Arbor
Jan. 29-31	Annual Meeting of the MSMS Council, Sheraton-Cadillac Hotel	Detroit
Jan. 31	MSMS County Secretaries-Public Relations Seminar, Sheraton-Cadillac	
Feb. 1-2	Hotel	Detroit
Mar. 19-21	Michigan Clinical Institute, Sheraton-Cadillac Hotel	Detroit
Spring	MSMS Postgraduate Extramural Courses	Statewide

PR REPORT

SURVEY PUBLICITY GOES TO TOWN

The powerful press enabled the Michigan State Medical Society to wind up its Opinion Study of Prepaid Medical Care Coverage in Michigan with a flood of mail revealing opinions of over 12,000 people.

Through the timely cooperation of all media, the public became aware of the need to fill out and return their questionnaires—hence, a record-breaking response to the doctor's questions!

Over 5,000 releases hit the desks of Michigan's daily and weekly editors during this four-month period of concentrated publicity.

No medium escaped the engulfing publicity of the MSMS Study. TV editors were presented with attractive cartoon slides, and good copy to run at their good will.

Radio editors were handed hard-hitting announcements—urging the public to meet the questionnaire deadline. Five, fifteen, and thirty-minute radio shows hammered out the importance of the Study to the uninformed. A half hour TV show presented an interview in action.

Secretary's Letters kept the medical society secretaries, presidents, and editors up to date on Study progress. The Woman's Auxiliary and the Michigan State Medical Assistants Society were individually contacted by mail, informed of the Study, and enlisted to "get the doctors to return their questionnaires!"

Stories, pictures and cartoon mats felt the punch of the postage meter's tattoo as Michigan's publications heard about the Study. Organizations and associations were mailed copies of the questionnaire, suggested announcements for their group, and questionnaire request form cards.

The *Lansing State Journal* ran two-king-sized feature articles, pictures and the questionnaire. The *Detroit Times* printed the questionnaire, then relinquished choice space for an editorial and thought-provoking articles.

Announcements of the Study pierced the cork of insurance companies' bulletin boards; telegrams were dispatched to hospital staff chiefs—urging doctors to get their questionnaires in, and the Detroit State Fair saw thousands winding their way to the MSMS booth to "Watch the slide show, take a guess for a bond, and while you're at it, take this informative material on the survey home with you!"

Here is *what* was read, seen and heard, about the MSMS Study:

Publicity Schedule for Opinion Study on Prepaid Medical Care Coverage in Michigan

May 23	Release: Announcement of the survey	372 newspapers 83 radio 13 TV
May 29	Release: Meeting of survey committee	372 newspapers 83 radio 13 TV
June 4	Release: Methods of obtaining information	372 newspapers 83 radio 13 TV
June 5	Secretary's Letter No. 191: To all presidents, secretaries and editors of component medical societies	124 people
June 10	1000-word article on study plans and progress	372 newspapers
	All organizations in Michigan Health Council Directory	
	All voting members of Michigan Health Council	45
June 21	Letter to members Capital Club, enclosing article for their bulletins	50 members (representing 120,000 opinion leaders)
June 21	Release: Survey questions	372 newspapers
June 23	Release: "Lansing used as test city" (Feature)	*Lansing State Journal*

Flu Fight

Drug Firms Speed U
Vaccine Output, But
Will the U.S. Need I

Asiatic Virus Raises Threa
Government Buys, Pro
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en Attack, Rapid Sprea

8 STUDENTS ON FLIGHTS TO U. S. HAVE ASIAN FLU

New York, Aug. 15 (
Laboratory tests on e
foreign exchange student
arrived Aug. 8 show they
victims of Asiatic flu, the
health department repo
today. The eight arrived
plane from Europe.

Twenty-nine other stud
suffering from influenza
rived Tuesday from Rot
dam on the ship Arosa Sky.
One, Nicholas Memmos,
Greek exchange student,
yesterday. Six of these stu-
dents were released today
the others are to be r
tomorrow. It has not
termined whether
died from Asiatic

THE INFLUEN
How Deadly Will it Be
What Can We Do abou

'he War on Mutant A

If Florence was in the grip of an epi-
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Asian Flu: the Outlook

Asian influenza will hit the U.S. this fall before mass immunization can be effective, and the nation faces an epidemic which may strike 15 million to 30 million people. The disease is relatively mild (in no way comparable to the killing "Spanish flu" of 1918-19), and is likely to cause only a small number of deaths among the feeble young and enfeebled old. But it may compel 10% to 20% of the population in affected areas to tak
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U.S. Fighting As

The War On Asiatic Flu

There's cause for concern about Asiatic flu, but scientists and public health officials see no reason for anyone to panic.

First shipments of the vaccine against the new influenza strain have arrived in Chicago, setting off a flood of telephone calls from worried patients to doctors, and from doctors to drug suppliers. This is a nor
pattern of mass fear and is understan
The of the

Even though Salk vaccine priorities were necessary, the regulation produced administrative headaches, public complaints and probably a gray, if not a black market. When regulation
invoke it.
would

PUBLIC HEALTH

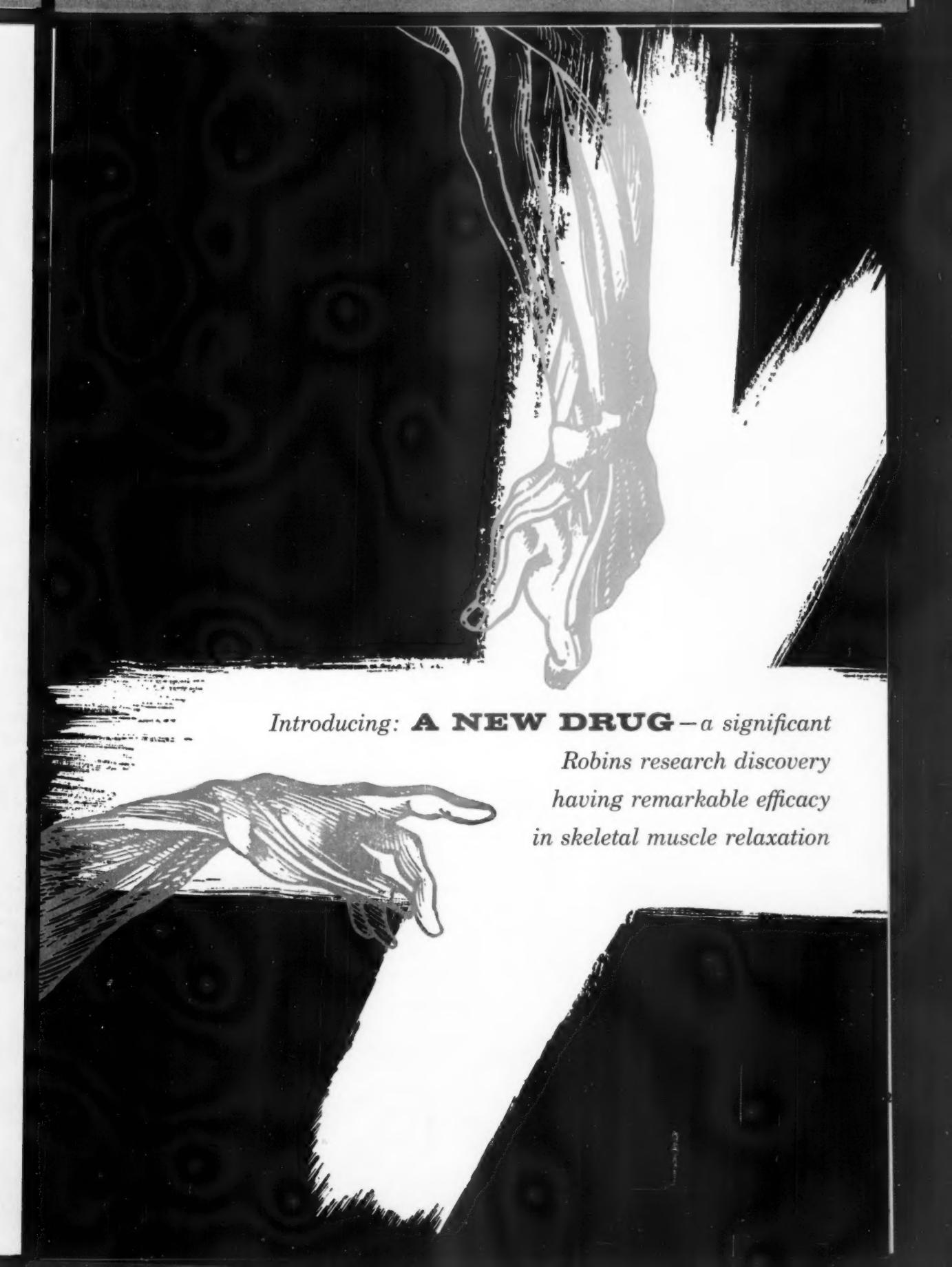
Influenza Ma

➤ INFLUENZA, one of the most unpredictable of communicable diseases, is resting "on cat feet" across the nation right now. It has already struck once this year in mild epidemic form at an Air Force base in Colorado. When and how severely it will strike again is a perennial riddle to public health authorities.

It will probably not lie dormant for the rest of the winter months. At the least there will be sporadic outbr
throughout the country. If
ditions occur, it could sw

(Continued from Page 1212)

June 24	Letter to editors containing two suggested editorials and the survey timetable	372 newspapers
June 26-July 1	Release: County mailings of survey questionnaires going out; release was sent to editors of the respective counties informing them their area was due to receive mail questionnaires	372 newspapers
July 5	Secretary's Letter No. 192: To members of MSMS House of Delegates and presidents, secretaries and editors	260 officers and editors
July 7	30 minute TV show announcing the study	WJBK
July 12	Letter informing of survey and questionnaire to all Better Business Bureaus, Chambers of Commerce in Michigan	400 organizations
July 12	Article on plans of the study	*Women's Auxiliary Bulletin*
July 14	2-column editorial and questionnaire printed in full	*Detroit Times*
July 14	Questionnaire printed in full	*Lansing State Journal*
July 16	Letters to Service Clubs in Michigan, enclosing questionnaire. Suggested announcement and reply card.	750 club secretaries
July 18	Letter to Capital Club members, enclosing questionnaire	50 members (representing 120,000 top opinion leaders)
July 18	Letter to presidents of all County Medical Societies	55 presidents
July 18	Letter to secretary of each County Medical Society, with release	55 secretaries
July 19	Special story about study	*Medical Economics*
July 19	Bulletin board announcements regarding study to interested companies	60 announcements
July 19	Letter to all Michigan TV program managers from Michigan Health Council, with two slides and newscast insertion for 2-30 second spot announcements	13 TV stations
July 19	Letter to all Michigan radio program managers from Michigan Health Council with 4-30 second spot announcements.	63 radio stations
July 20	Release: To all papers in St. Joseph County re: first person to return questionnaire	6 newspapers
July 22	Release: to County Medical Society presidents	55 presidents
About July 15	Release: for use in Association publications with enclosure of survey questionnaire	340 publications
July 25	Release: Details regarding study, went out through Michigan Press	372 newspapers
July 25	Release: Feature about Study	*Lansing State Journal*
July 25	Picture of Circuit Judge Marvin Salmon of Lansing being personally interviewed	*Lansing State Journal*
July 25	Release to editors all County Medical Society bulletins	14 editors
July 26	Release: Barry Laboratories, Inc.	1 company publication
July 26	Story: Special article re: study for Bureau of Business Research, MSU.	1 publication
July 26	Mailing to officers and committee chairman of MSMS Women's Auxiliary, county and state, to inform of survey and enlist co-operation	118 officers
July 26	Mailing to all MSMS Women's Auxiliary to inform of survey and enlist co-operation	3200 members
July 29	Telegram to chiefs of hospital staff urging doctors to fill out questionnaires	200 chiefs of staff
July 29	Mailing to all members Michigan State Medical Assistant Society	800 members
July 30	15-minute "Farm and Home" radio show re: Study	WKAR radio
Aug. 1	Release: Announcing rate of returns (Michigan Press)	385 newspapers
Aug. 10	5-minute radio tape about Study—"What it means to *you*"	67 radio stations
Aug. 15	Release: Response and number of returns (MHC)	372 newspapers
Aug. 16	Story to all company publications and house organs in Michigan, enclosing carton mats and article	192 publications
Aug. 26	Feature article	*Detroit Times*
Aug. 29	Secretary's Letter No. 193, to presidents, secretaries, editors, all component medical societies	124 officers and editors
Aug. 30 to Sept.8	State Fair, MSMS exhibit booth on Study	
Aug. 30	Release: Announcement of pilgrimage to Annual Session MSMS	372 newspapers
Sept. 15	30-minute radio show: Doctors Foster, Lightbody and Lichter	WJBK
Sept. 17	Release: Annual Session—Results to be revealed (Michigan Press)	385 newspapers


Introducing: **A NEW DRUG**—*a significant*
Robins research discovery
having remarkable efficacy
in skeletal muscle relaxation

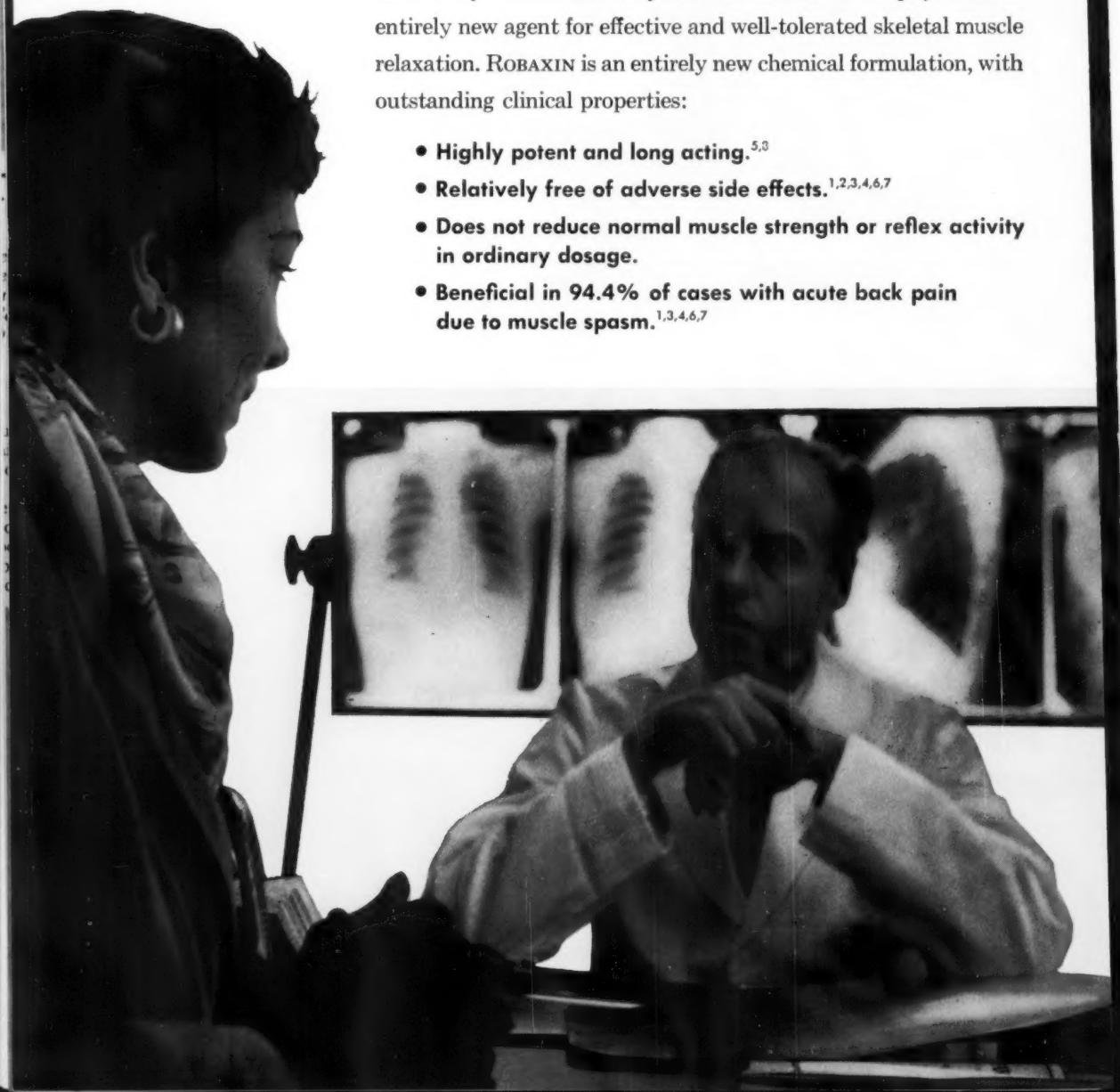
Significant **Robins** research discovery:

a highly efficient skeletal muscle relaxant

Ro

ROBAXIN – synthesized in the Robins Research Laboratories, and intensively studied for five years – introduces to the physician an entirely new agent for effective and well-tolerated skeletal muscle relaxation. ROBAXIN is an entirely new chemical formulation, with outstanding clinical properties:

- **Highly potent and long acting.**[5,8]
- **Relatively free of adverse side effects.**[1,2,3,4,6,7]
- **Does not reduce normal muscle strength or reflex activity in ordinary dosage.**
- **Beneficial in 94.4% of cases with acute back pain due to muscle spasm.**[1,3,4,6,7]



obaxin®

(Methocarbamol Robins, U.S. Pat. No. 2770649)

Highly specific action

ROBAXIN is highly specific in its action on the internuncial neurons of the spinal cord – with inherently sustained repression of multisynaptic reflexes, but with no demonstrable effect on monosynaptic reflexes. It thus is useful in the control of skeletal muscle spasm, tremor and other manifestations of hyperactivity, as well as the pain incident to spasm, without impairing strength or normal neuromuscular function.

Beneficial in 94.4% of cases tested

When tested in 72 patients with acute back pain involving muscle spasm, ROBAXIN induced marked relief in 59, moderate relief in 6, and slight relief in 3 – or an over-all beneficial effect in 94.4%.[1,3,4,6,7] No side effects occurred in 64 of the patients, and only slight side effects in 8. In studies of 129 patients, moderate or negligible side effects occurred in only 6.2%.[1,2,3,4,6,7]

CLINICAL RESULTS WITH ROBAXIN IN ACUTE BACK PAIN[1,3,4,6,7]

Disease entity	*No. of Cases*	*Duration of Treatment*	*Dose per day (divided)*	*Response*				*Side Effects*
				Marked	*Mod.*	*Slight*	*Neg.*	
Acute back pain due to								
(a) Muscle spasm secondary to sprain	18	2-42 days	3-6 Gm.	17	1	0	0	None, 16; Dizziness, 1; Slight nausea, 1.
(b) Muscle spasm due to trauma	13	1-42 days	2-6 Gm.	8	1	3	1	None, 12; Nervousness, 1.
(c) Muscle spasm due to nerve irritation	5	4-240 days	2.25-6 Gm	4	1	0	0	None, 5.
(d) Muscle spasm secondary to discogenic disease and postoperative orthopedic procedures	30	2-28 days	1.5-9 Gm.	24	3	0	3	None, 25; Dizziness, 1; Lightheadedness, 2 Nausea, 2.*
Miscellaneous (bursitis, torticollis, etc.)	6	3-60 days	4-8 Gm.	6	0	0	0	None, 6.
TOTAL	72			59	6	3	4	

*Relieved on reduction of dose

NOW

a highly specific skeletal muscle relaxant...

Robaxin®

(Methocarbamol Robins)

This new drug—for use in the control of skeletal muscle hyperactivity in many disease states manifesting neuromuscular dysfunction—is available NOW on your prescription at all leading pharmacies. Informational literature is available on request.

Indications:

Acute back pain associated with: (a) muscle spasm secondary to sprain; (b) muscle spasm due to trauma; (c) muscle spasm due to nerve irritation; (d) muscle spasm secondary to discogenic disease and postoperative orthopedic procedures; and (e) miscellaneous conditions such as bursitis, torticollis, and related conditions.

Dosage:

ADULTS: 2 tablets 4 times a day to 3 tablets 6 times a day.

CHILDREN: Total daily dosage 270 to 335 mg. per 10 pounds of body weight, adjusted for age and weight, and divided into 4 to 6 doses per day.

Supplied:

ROBAXIN Tablets (white, scored), each containing methocarbamol [3-(o-methoxyphenoxy)-2-hydroxypropyl-1-carbamate], 0.5 Gm. Bottles of 50.

References:

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AMA Washington Letter

THE MONTH IN WASHINGTON

In the last few years interest has built up in the problems of the older people—how they are to get their bills paid, how to spend their time constructively, what chronic medical conditions are causing them the most trouble. Innumerable national and local conferences have searched for ways to make life more satisfying and healthy for people entering old age, and committees are at work on the problem in thousands of communities.

In this favorable climate, when every device that might help the older citizens is being examined, there is being revived a scheme that met with no success at all when first proposed more than six years ago.

It is a plan for government-paid hospitalization under the Old Age and Survivors' Insurance system.

Here is the argument that is made for it:

People in old age generally have less income than when they were younger, but at the same time they require more medical attention and hospital care. Neither voluntary nor commercial health insurance has been able to offer these people the protection they need. The only solution, sponsors of the plan say, is to get the federal government into the picture.

Opponents of the idea agree that older people are sick more often and generally don't have much money, but they disagree violently with the other arguments. They point out that slowly but surely insurance coverage is being extended to older people at a price they can afford to pay. Most important, hospitalization-at-sixty-five critics maintain that a system like this is in effect national compulsory health insurance under Social Security.

Early this year Reps. Emanuel Celler (D., N. Y.) and John Dingell (D., Mich.) introduced bills on this subject. They would allow sixty days a year free hospitalization for OASI-covered men sixty-five and over and women sixty-two and over. Rep. Kenneth A. Roberts (D., Ala.) offered a similar bill.

Just before the session ended two developments occurred that are evidence the proponents of this system of hospitalization are getting ready to make a real fight for it next year.

First, Rep. Aime J. Forand (D., R. I.) presented a bill that would make extensive liberalizations in the social security program, including creation of a hospitalization that would give free surgical service to the aged program. Some national labor leaders immediately pledged their support to this bill, a not unexpected move as the AFL-CIO is officially behind the general idea.

Then Senator Richard L. Neuberger (D., Oregon) made it plain he, too, wanted the old people to have free in-hospital medical care. The senator said he hadn't firmed up his thoughts, but that he believed the best approach would be something like the Military Dependent Medical Care program (Medicare), making use of Blue Cross or other nonprofit groups. He estimates that a 1 per cent increase in payroll taxes for both employer and employee would meet the extra costs.

Mr. Forand, on the other hand, is specific. He would make all persons receiving OASI retirement benefits eligible and also surviving widows and children, but would not include persons receiving OASI disability payments. He would broaden the time period by allowing 120 days of hospital or nursing home care each year, with hospital stays limited to sixty days.

The Forand measure also has a provision, not contained in most earlier bills, for OASI also to pay for in-hospital surgical services certified as necessary by the physician.

Mr. Forand would take no chance of running out of money. He would levy social security payroll taxes on all income up to $6,000 (present limit $4,200), and also increase the tax rate a half per cent for employer and employee alike, and three-quarters of one per cent for the self-employed.

It is almost certain that these and other similar suggestions will receive serious consideration by Congress next year, with passage of a bill much more likely than in 1951 when President Truman and Oscar Ewing first proposed the idea.

NOTES:

When Congress returns January 7, one of the measures waiting its attention will be a bill to control union welfare funds through registration and publicity. (Most funds involve medical-hospital benefits.)

* * *

Jenkins-Keogh legislation, for deferment of income taxes on money put into retirement plans by the self-employed, now is assured of a hearing next year when the House Ways and Means Committee goes into all phases of taxation.

* * *

The Atomic Energy Commission has made its 100,000th shipment of radioisotopes, many of them for medical use.

The
Upjohn Company
announces
a major
corticosteroid
improvement

minor chemical changes can mean major therapeutic improvements

Medrol*

The most efficient of all anti-inflammatory steroids

- Lower dosage (⅓ lower dosage than prednisolone)
- Better tolerated (less sodium retention, less gastric irritation)

Supplied: Tablets of 4 mg., in bottles of 30 and 100.

*TRADEMARK FOR METHYLPREDNISOLONE, UPJOHN

For complete information, consult your Upjohn representative, or write the Medical Department, The Upjohn Company, Kalamazoo, Michigan.

Upjohn

New Chemotherapy

ARALEN® *in* RHEUMATOID ARTHRITIS

Extensive studies of rheumatoid arthritis and related collagen diseases—in this country and abroad—have shown the antimalarial Aralen phosphate to be highly effective and well tolerated in a large percentage of patients.

Clinical Results with Aralen in Rheumatoid Arthritis

Author	No. of Cases	Major Improvement	Minor Improvement	No Effect
Heyde[1]	28	22	5	1
Rinehart[2]	25	12	4	9
Freedman[3]	50	43	3	4
Bagnall[4]	108	77	12	19
Bruckner[5]	36	32	0	4
Cohen and Calkins[6]	22	17	3	2
Scherbel et al.[7]	25	9	8	8
Total	294	212 (72%)	35 (12%)	47 (16%)

- Success dependent upon persistent treatment
- Often of benefit where other agents have failed
- Remissions on therapy well maintained
- Remission of 3 to 12 months possible even if treatment is interrupted
- Tachyphylaxis not evident

GENERAL EFFECTS:

- Patient feels better
- Patient looks better
- Exercise tolerance increases
- Walking speed and hand grip improves

LABORATORY EFFECTS:

- E. S. R. may fall slowly
- Hemoglobin level may gradually rise

ANALGESICS AND STEROIDS:

- Requirements usually reduced or eliminated

JOINT EFFECTS:

- Pain and tenderness relieved
- Mobility increases
- Swellings diminish or disappear
- Muscle strength improves
- Rheumatic nodules may disappear
- Even severe or advanced deformity may improve
- *Active* inflammatory process usually subsides
- Joint effusion may diminish

DOSAGE:

Aralen is cumulative in action and requires four to twelve weeks of administration before therapeutic effects become apparent.

Latest information indicates that an initial dose of 250 mg. of Aralen phosphate is preferable to the higher doses sometimes recommended. However, If side effects appear, withdraw Aralen for several days until they subside. Reinstate treatment with 125 mg. daily and, if well tolerated, increase to 250 mg. The usual maintenance dose is 250 mg. daily.

New Chemotherapy

INDICATIONS:

- Rheumatoid arthritis, acute or chronic —with or without adjunctive therapy.
- Spondylitis
- Arthritis associated with lupus erythematosus or psoriasis

THEORY OF ACTION:

Aralen appears to suppress or induce remission of rheumatoid inflammatory processes by inhibiting adenosinetriphosphatase.

HOW SUPPLIED:

Aralen phosphate: 250 mg. tablets in bottles of 100 and 1000.
125 mg. tablets in bottles of 100.

Tolerance:

Aralen is usually well tolerated. Toxic effects are usually mild and to date have been transitory in nature, disappearing completely either on continuance or cessation of therapy or on reduction in dosage.

Gastrointestinal disturbances (e.g. nausea, rarely vomiting, diarrhea, abdominal cramps, anorexia) are frequent manifestations of intolerance. Temporary blurring of vision (due to interference with accommodation) is also relatively frequent.

Pleomorphic skin eruptions (e.g. lichenoid, maculopapular, purpuric), although generally mild, may preclude the use of an optimum dosage schedule. If a skin reaction persists on a reduced dosage schedule, or recurs after reinstitution of treatment with gradually increasing doses, discontinue Aralen till the lesion again disappears and consider resuming treatment with Plaquenil® (brand of hydroxychloroquine).

Less frequently transitory vertigo, headache, lassitude, or neurological disturbances, such as nervousness, irritability, emotional change, and nightmares have been reported. Instances of unexplained slight gradual weight loss as the patient's general health and arthritic condition improved have been mentioned. Occasional instances of bleaching (depigmentation) of the hair have been described.

Although an occasional instance of leukopenia, with normal differential count, has been reported (WBC about 3000), it has not proved troublesome because it has always been reversible on discontinuance, or diminution of the dose. Even spontaneous reversal may occur while full dosage is maintained.

Caution:

Aralen is known to concentrate in the liver and, although hepatic damage has never been reported, the drug should be used with caution in the presence of liver disease. In the presence of severe gastrointestinal, neurological, or blood disorders, the drug should be used with caution or not at all. If such disorders occur during the course of therapy, the drug should be discontinued. Concomitant use of gold or phenylbutazone with Aralen should be avoided because of the tendency of these agents to produce drug dermatitis.

Clinical Comments:

Of fifty patients receiving Aralen therapy, "43 have become really well; that is, they have no stiffness, and any pain that occurs can reasonably be attributed to use of joints affected by secondary degenerative changes. They have no evidence of joint inflammation, but may have a raised erythrocyte sedimentation rate. They have little or no need for analgesics." *Freedman*[3]

"One hundred and twenty-five private patients have been carefully followed clinically and haematologically while receiving well over 200 patient-years of chloroquine [Aralen] therapy. The results are considered good in 70%, one-half of these cases being in remission. Improved work performance, sedimentation rate, and hemoglobin levels paralleled the major objective gain in this 70%. 90% of them remained on chloroquine [Aralen] therapy, half for more than two years. Classical peripheral rheumatoid arthritis, spondylitis, arthritis of juvenile onset, and rheumatoid disease with psoriasis, all appeared to respond about equally well.

"It is suggested that chloroquine comes closer to the ideal for long-term, safe, control of rheumatoid disease than any other agent now available." *Bagnall*[4]

"Out of the 36 rheumatoid arthritis cases we treated . . . favorable results were obtained in 32 cases. *Bruckner et al.*[5]

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4. Bagnall, A.W.: The value of chloroquine in rheumatoid disease, a four year study of continuous therapy, read at the Ninth International Congress on Rheumatic Diseases in Toronto, Canada, June 23-28, 1957.
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AMA News Notes

AMA PLANS ELEVENTH CLINICAL MEETING

The birthplace of American independence—Philadelphia—will be the scene of the American Medical Association's 11th Clinical Meeting, December 3-6. Center of activities will be Convention Hall where scientific exhibits, color television, motion pictures, technical exhibits and scientific lectures will be presented "under one roof." Headquarters for the House of Delegates will be the Bellevue-Stratford Hotel.

Highlights of the three-and-a-half day convention geared especially for the nation's family doctors include: (1) Special transatlantic conference between distinguished physicians in London and Philadelphia on "Advances in Chemotherapy of Cancer" via two-way telephone at 3 p.m. EST Wednesday; (2) complete color television schedule of surgical demonstrations emanating from Lankenau Hospital; (3) motion picture program daily, plus a special session Tuesday evening; (4) exhibits featuring a well-rounded program and special displays on the history of medicine in the Philadelphia area, fractures and manikin demonstrations on problems of delivery; (5) panel discussions on cardiovascular disease, cancer, emotional problems of menopause, hypertension, diabetes, arthritis, traumatic injuries; (6) the General Practitioner of the Year Award to be presented by AMA to an outstanding family doctor.

AD INDUSTRY TO JOIN BATTLE AGAINST POLIO

Local polio drives will get publicity assistance this fall from the Advertising Council, Inc. This voluntary group of advertisers and businessmen has taken on the vaccine campaign as one of its public service projects, mapping out a complete promotional program which utilizes newspapers, business papers, industrial publications, transportation and outdoor advertising, as well as radio and television. Local use of these materials will, in many cases, depend on whether or not a community vaccination drive has been planned or is in progress.

Using the theme "Don't Press Your Luck—Get Your Three Polio Shots Now!", the materials make frank use of scare techniques by contrasting the tragic effects of polio with the simplicity of getting Salk shots. Advisors for the campaign were the American Medical Association, the U. S. Public Health Service and the National Foundation for Infantile Paralysis.

U. S. TO OBSERVE "MEDICAL EDUCATION WEEK" IN APRIL

The third annual Medical Education Week, nationwide tribute to the progress of American medical schools, will be promoted during the fourth week in April by U. S. medical schools and the medical profession.

April 20-26 will be devoted to an all-out effort to create a greater understanding among the public of both the achievements and the problems of medical schools. Each of the sponsoring organizations—the American Medical Association, the Student American Medical Association, the Woman's Auxiliary to the AMA, the Association of American Medical Colleges, the American Medical Education Foundation, and the National Fund for Medical Education—is asking its membership to reserve this week for community and statewide salutes to area medical schools.

Local and state programs will be reinforced by national publicity through network television and radio, newspaper syndicates, and magazines. In addition, the sponsors will send promotional aids to their state and county officers to help in local observances.

During the 1957 Medical Education Week, medical societies in thirty-two states and woman's auxiliaries in forty-two states planned various activities, and their past successes are expected to lead to an even more widespread acknowledgment of the achievements of medical schools in 1958.

AMA PARTICIPATES IN SAFETY CONGRESS

America's doctors will again join in presenting a program this fall at the National Safety Congress in Chicago. The AMA's Council on Industrial Health will co-sponsor a session on "Vision in Industry" with the American Society of Safety Engineers and the National Safety Council's occupational health nursing section. Among the areas to be covered in the discussion of eye safety programs are visual ability to meet job requirements, eye protection, and proper first aid for eye injuries. This program will be held Thursday morning, October 24, at the Congress Hotel.

AMA PREPARES LIABILITY KITS

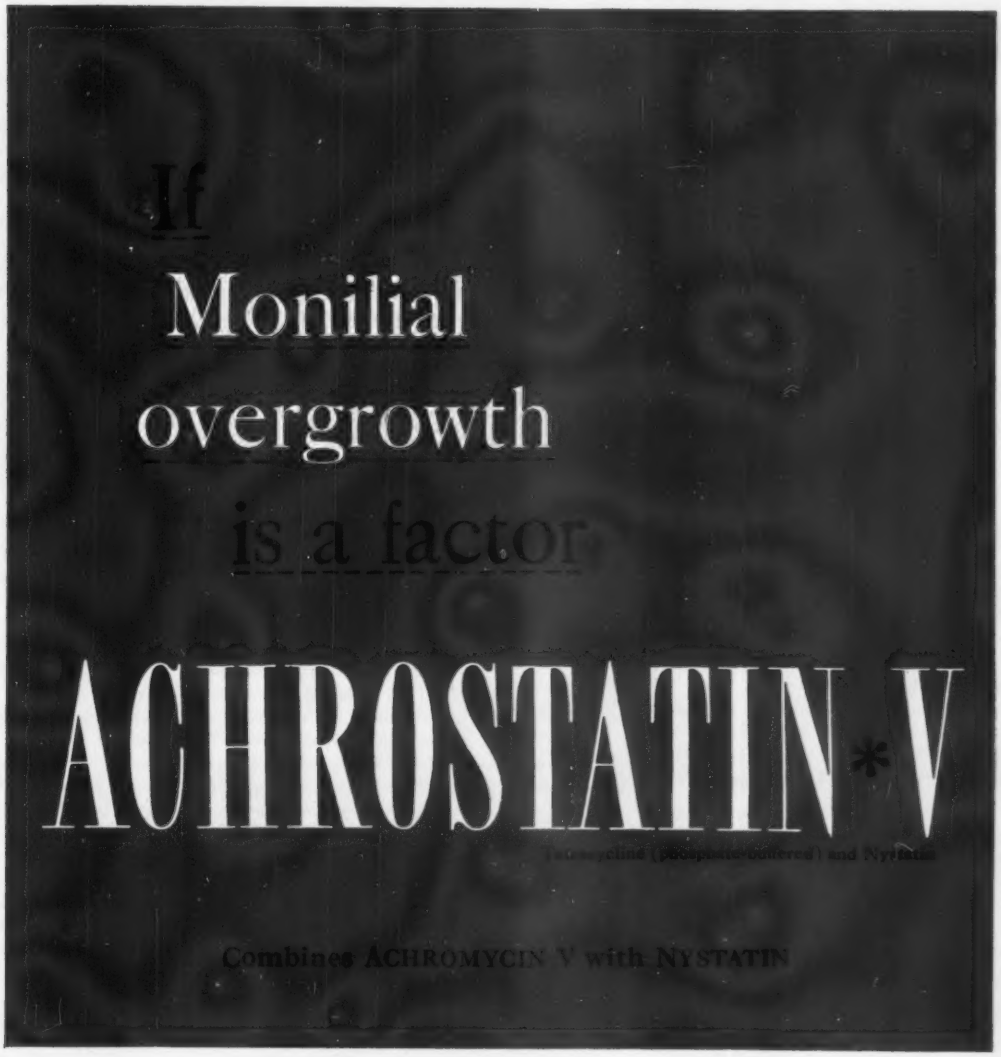
For us in claims prevention and claims review programs, the American Medical Association's Law Department is making available to each state medical society a packet of materials dealing with "medical professional liability." The kit will contain reprints from the *Journal of the American Medical Association* "Medicine and the Law" section dealing with such things as statues of limitation, court decisions and *"res ipsa loquitur."* Also enclosed will be the results of an opinion survey and a report on medical professional liability case histories, keyed to each state. Distribution is slated for October 1.

M.D.'s TO CO-OPERATE IN "FARM-CITY WEEK"

The national committee for Farm-City Week, November 22-28, has extended a special invitation to all state and county medical societies to join in a program to "build better relationships between town and country neighbors." As in the past two years, this observance will be conducted nationally and locally by hundreds of civic, industrial, agricultural, professional and youth organizations—all spearheaded and coordinated by Kiwanis International.

The AMA, which is represented on the Farm-City

(Continued on Page 1224)



ACHROSTATIN V combines ACHROMYCIN† V... the new rapid-acting oral form of ACHROMYCIN† Tetracycline... noted for its outstanding effectiveness against more than 50 different infections... and NYSTATIN... the antifungal specific. ACHROSTATIN V provides particularly effective therapy for those patients who are prone to monilial overgrowth during a protracted course of antibiotic treatment.

supplied:
ACHROSTATIN V CAPSULES contain 250 mg. tetracycline HCl equivalent (phosphate-buffered) and 250,000 units Nystatin.

dosage:
Basic oral dosage (6-7 mg. per lb. body weight per day) in the average adult is 4 capsules of ACHROSTATIN V per day, equivalent to 1 Gm. of ACHROMYCIN V.

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M.D.'S TO CO-OPERATE IN "FARM-CITY WEEK"

(Continued from Page 1222)

board of directors, this month (October) will send to all societies a series of suggestions for highlighting their urban and rural health services during the Week. In most cases, local programs will be coordinated by community Kiwanis clubs. Names of both regional and state Farm-City Week chairmen also will be sent to medical societies so that physicians may be represented on the local planning committees.

THREE NEW AMA EXHIBITS

Three new exhibits previewed at the American Medical Association's 1957 Public Relations Institute in Chicago, August 28-29, will be available for bookings by state and county medical societies in September.

(1) "Digestion"—shows the organs involved in digestion, the passage of food through the body, the mechanics of swallowing, the action of the stomach and intestines, and the body's absorption of food. (2) "Alcoholism Is Your Business"—(for professional audiences) gives the viewer an opportunity to eavesdrop on a conversation between a distraught spouse and the family physician over the treatment of alcoholism. (3) "Organs of the Human Body"—three dimensional models of the torso show location of various organs in the body and their functions.

Further information on these displays may be secured from the AMA Bureau of Exhibits.

AMA TO PUBLISH MEDICOLEGAL MATERIAL

To guide physicians and hospitals in the selection of appropriate medicolegal forms, the AMA's Law Department has compiled a series of six brief articles for the *Journal of the AMA*. These articles will appear weekly in the *Journal*, beginning about September 1. In addition, the Law Department will publish a booklet encompassing the material plus case citations and legal analysis for distribution about October 1.

Chief purpose of this material will be to provide up-to-date information and miscellaneous medicolegal forms which physicians and their attorneys may adapt for their own needs. Subjects to be covered: (1) consent to operations and other medical procedures; (2) patient's right to privacy; (3) confidential communications and records; (4) artificial insemination; (5) the physician-patient relationship; (6) autopsy.

In all cases, the Law Department strongly advises doctors to seek competent legal advice locally.

AMA LENDS HAND TO MEDICAL ASSISTANTS GROUPS

A new how-to-do-it organizational manual for medical assistants will be introduced at the second national convention of the American Association of Medical Assistants in San Francisco, October 4-6. Edited by leaders in assistants groups around the country, the manual is being published by the AMA's Public Relations Department. The manual, titled "Take-off Techniques," discusses such organizational processes as securing medical society cooperation, planning educational programs and keeping members informed.

This is the second publication for medical assistants the AMA has prepared this fall. A new medical assistants packet, outlining medical assistants' organizational aims and activities, was completed recently and is available on request to medical societies and assistants groups.

Women from assistants groups in some twenty states are expected to attend the San Francisco session of AAMA. The San Francisco Medical Society, the California Medical Association and the AMA will co-sponsor a reception Friday evening, October 4, for AAMA members.

AMA CONFERENCE ON NUTRITION IN PREGNANCY

Because nutrition plays such an important role in all phases of reproduction, the AMA's Council on Foods and Nutrition has selected "Nutrition in Pregnancy" as the title of its 1957 symposium. The meeting will be held October 11 at the University of Missouri Medical Center, Columbia, Missouri. Joint sponsors with the AMA are the University of Missouri Medical School and Adult Education and Extension Service and the Boone County Medical Society.

The symposium will provide an excellent opportunity for physicians, nutritionists, dietitians, nurses and others to acquaint themselves with current findings in nutrition and the practical application of these findings to the management of obstetrical patients.

Topics to be discussed include: the influence of maternal nutritional level on the fetus and infant; metabolic and biochemical changes in normal pregnancy; importance of nutritional state of mother prior to conception; nutrition experiments as an instrument of teratologic research; the effect of the reproductive cycle on nutritional status and requirements; dietary habits during pregnancy; panel discussion to review epidemiologic studies.

If physicians and patients alike maintain a high index of suspicion, and if all available diagnostic procedures are utilized, many more cases of esophageal and gastric cancer will undoubtedly be uncovered while still in a stage permitting curative operation.

* * *

The great pitfall in cytologic examination is the false negative result. A negative cytologic study does *not* exclude the diagnosis of cancer.

* * *

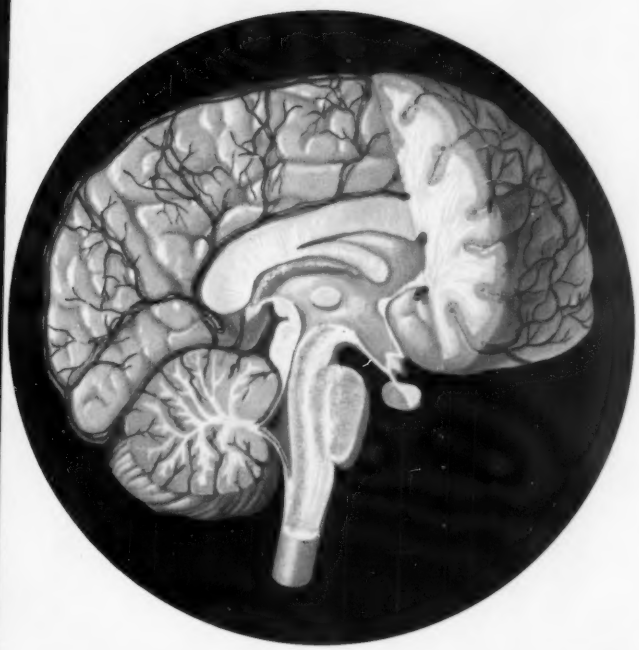
There is no single characteristic onset or symptom complex in the earliest expressive stage of gastric cancer.

* * *

Any symptom referable to the upper abdomen may be a symptom of cancer of the stomach.

* * *

Approximately one-third of all patients with gastric cancer may present symptoms of peptic ulcer.

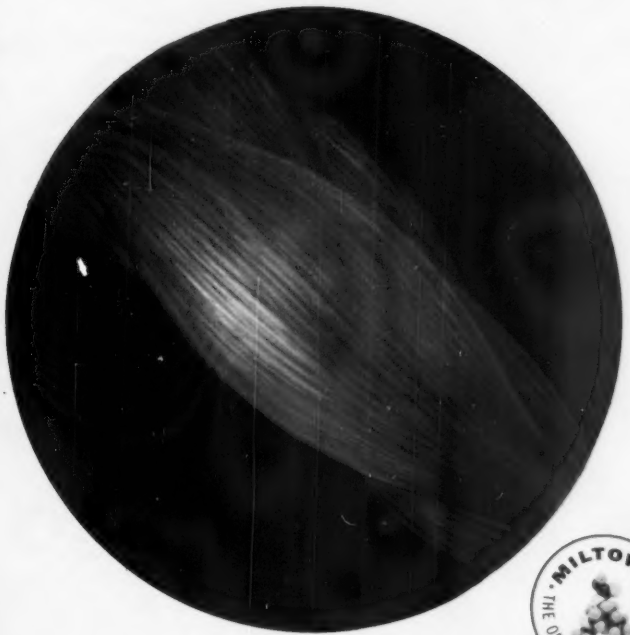


For anxiety, tension and muscle spasm in everyday practice.

- well suited for prolonged therapy
- well tolerated, relatively nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness

RELAXES BOTH MIND AND MUSCLE

WITHOUT IMPAIRING MENTAL OR PHYSICAL EFFICIENCY



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2-methyl-2-**n**-propyl-1,3-propanediol dicarbamate — U. S. Patent 2,724,720

Supplied: 400 mg. scored tablets
200 mg. sugar-coated tablets

Usual dosage: One or two 400 mg. tablets t.i.d.

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AN IMPORTANT ADVANCE IN MENOPAUSAL THERAPY

Because it replaces *half* control with *full* control.

Because it treats the *whole* menopausal syndrome.

Because *one* prescription manages *both* the psychic and somatic symptoms.

SUPPLIED: Bottles of 60 tablets.
Each tablet contains:

MILTOWN® (meprobamate, Wallace) ..... **400 mg.**
2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate.
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Conjugated Estrogens (equine) ..... **0.4 mg.**
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DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.

Samples and literature on request.

Two-dimensional treatment of the menopause

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A Proven Tranquilizer
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WALLACE LABORATORIES, *New Brunswick, N. J.*
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» unexcelled antihistaminic action

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (3)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

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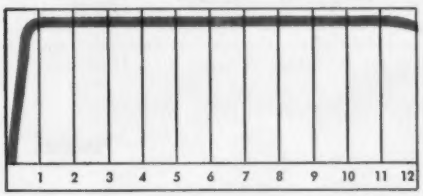

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Dosage:

Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12 h. or twice daily.

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Social Security and Jenkins-Keogh Bills

Actions of the AMA House of Delegates at its June, 1957 annual meeting on these subjects were as follows:

1238

No. 23. Resolution on Postponement of Income Tax Payments

The following resolution was introduced by Dr. James E. Feldmayer on behalf of the California delegation and was referred to the Reference Committee on Insurance and Medical Service:

WHEREAS, The California Medical Association has declared itself in favor of the U. S. House of Representatives Resolutions 9 and 10 permitting postponement of payment of income tax on certain sums earned by self-employed persons, known as the Reed-Keogh bills; now, therefore be it

Resolved, That the California Medical Association does urge the American Medical Association to continue its strenuous efforts toward the passage of this or similar legislation.

REPORT OF REFERENCE COMMITTEE ON INSURANCE AND MEDICAL SERVICE

Dr. James P. Hammond, Chairman, Vermont, read the following report, which was adopted:

Resolutions No. 23, 40, and 57 on the Jenkins-Keogh Bills.—The subject matter of these resolutions is identical, and the purpose of all of them is to endorse the Jenkins-Keogh bills. Your committee recommends that they be adopted.

1243

No. 39. Resolutions on Social Security Benefits

Dr. Christopher Wood for the New York delegation introduced the following resolutions, which were referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, 70 million Americans are currently eligible for retirement and survivors benefits under the Federal Social Security system; and

WHEREAS, Congress amended the Social Security Act in 1954 and 1956 bringing self-employed professionals, such as dentists, lawyers, pharmacists, social workers, engineers, and others, the benefits of Old-Age and Survivor's Insurance; and

WHEREAS, Doctors of medicine are now the sole self-employed professional group excluded; and

WHEREAS, Because of this unfair exclusion physicians must pay $7,000 to $25,000 more for retirement and life insurance than other citizens; and

WHEREAS, There is no logical or professional reason why practicing physicians should be denied benefits available to millions of other Americans; and

WHEREAS, Congress has passed bills whereby no voluntary coverage will be granted physicians; therefore be it

Resolved, That the American Medical Association rescinds its opposition to compulsory social security for doctors of medicine; and be it further

Resolved, That we urge the Congress of the United States of America to extend the benefits of social security to self-employed doctors of medicine; and be it further

Resolved, That the President of the United States of America, the presiding officer of the Senate, the Speaker of the House of Representatives, and members of appropriate congressional committees be sent copies of this resolution.

REPORT OF REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

Dr. S. J. McClendon, Chairman, California, read the following report which was adopted:

Resolutions No. 39 and 46 on Compulsory Social Security Coverage for Physicians.—Your committee heard a number of persons relative to these resolutions, and makes the following recommendations:

That the House of Delegates reaffirm its long-standing opposition to the compulsory coverage of physicians under the Old-Age and Survivors Insurance provisions of the Social Security Act. It recommends a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue.

Physicians and medical societies have for many years led the fight against federal encroachments in their personal and private affairs. The pattern of social insurance schemes in other countries growing from retirement payments to survivorship payments to permanent and total disability payments to temporary cash sickness benefits and, finally, to national compulsory health insurance, is all too clear. It is equally clear that greater federal control and the placing of responsibility for an increasingly greater percentage of our people in the hands of the government will result in loss of freedoms impossible to reclaim. For these reasons, and because of the actuarial instability of the Old-Age and Survivors Insurance program, your reference committee recommends that these resolutions be not adopted.

The Association's position favoring the Jenkins-Keogh bills is a more logical approach, as it encourages thrift and discourages inflation and dependence upon the federal government.

No. 40. Resolution on Participation of Physicians in Pension Plan for Self-Employed

The following resolution was introduced by Dr. Edward P. Flood on behalf of the New York delegation and was referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, It is desirable for physicians to receive tax-free pension rights; and

WHEREAS, Participation in such plans (Jenkins-Keogh bill) would not negate our participation in the Federal Social Security program; and

WHEREAS, Such participation would permit a self-employed physician to put part of his earnings before taxes into a retirement fund; therefore be it

Resolved, That the American Medical Association approves participation of its members in such a pension plan for the self-employed.

NOTE: The report of the Reference Committee on Legislation and Public Relations on Resolution No. 40 will be found following Resolution No. 23.

1245

No. 46. Resolution on Compulsory Social Security Coverage for Physicians

The following resolution was introduced by Dr. John N. Gallivan on behalf of the Connecticut delegation and was referred to the Reference Committee on Legislation and Public Relations:

(Continued on Page 1232)

(Continued from Page 1230)

WHEREAS, The Connecticut State Medical Society conducted a referendum among its 3,100 members during March and April of 1957 asking for a statement of opinion relative to the compulsory inclusion of doctors of medicine under Old-Age and Survivors Insurance in the Social Security Law; and

WHEREAS, 61 per cent of the members of the society voted in this referendum and 73 per cent of them were in favor of compulsory inclusion of doctors of medicine under the Social Security Law (which was 45 per cent of the total ballots distributed); and

WHEREAS, The House of Delegates of the Connecticut State Medical Society at its 165th annual meeting on April 30, 1957, directed the delegates from the society to the American Medical Association to present and support at the next meeting of the House of Delegates of the American Medical Association in New York City, June, 1957, a resolution sponsored by the Connecticut State Medical Society, favoring social security coverage for all physicians; now therefore be it

Resolved, That the House of Delegates of the American Medical Association assembled at its Annual Meeting in June, 1957, place itself on record as being in favor of compulsory inclusion of doctors of medicine under the Federal Social Security Law.

NOTE: The report of the Reference Committee on Legislation and Public Relations on Resolution No. 46 will be found following Resolution No. 39.

1248

No. 57. Resolutions Supporting the Jenkins-Keogh Bills

Dr. John K. Glen for the Texas delegation introduced the following resolutions, which were referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The legislation now pending in Congress, generally known as the Jenkins-Keogh bills, which would permit those with self-employment income to place a small part of their earnings before taxes into a retirement fund; and

WHEREAS, More widespread interest and support for the Jenkins-Keogh legislation is evident now than ever before, therefore be it

Resolved, That the House of Delegates of the American Medical Association again endorses the principles of the Jenkins-Keogh bills in the interest of fairness and equality to the self-employed individuals of the United States; and be it further

Resolved, That copies of this resolution be sent to the President, all members of his Cabinet, and all members of the Congress.

1251

No. 69. Resolutions on Nationwide Referendum on Social Security

Dr. Stanley Weld for the Connecticut State Medical Society introduced the following resolutions, which were referred to the Reference Committee on Legislation and Public Relations:

WHEREAS, The burning question of social security still confronts the physicians of the United States; and

WHEREAS, According to the statement of Frank G. Dickinson, Ph.D., Director, A.M.A. Bureau of Medical Economic Research, in *The Journal,* July 21, 1956, page 1163: "Unfortunately the use of a variety of questions in the state association polls makes a tabulation of the composite replies from all polls, particularly on the compulsory versus voluntary issue, meaningless"; therefore be it

Resolved, That the Secretary of the A.M.A. be instructed and empowered to conduct a nationwide referendum of the members of the A.M.A. on the issue of social security for self-employed physicians; and be it further

Resolved, That to obviate the confusion resulting from the statewide polls, the questions presented in the proposed referendum be phrased simply as follows:

I favor social security for physicians.

I do not favor social security for physicians.

and be it further

Resolved, That the referendum be preceded by the publication in *The Journal* of factual briefs for and against social security and that the same factual briefs shall also accompany the referendum ballots.

REPORT OF REFERENCE COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

Dr. S. J. McClendon, Chairman, California, read the following report, which was adopted:

Resolution No. 69 on Nationwide Referendum on Social Security.—Your committee met for two hours and listened to discussions for and against this resolution.

In its report on Resolutions No. 39 and 46, your committee has recommended "a strongly stepped-up informational program of education which will reach every member of the Association, explaining the reasons underlying the position of the House of Delegates on this issue."

From the discussions at the open hearing, it was obvious that such a program was necessary, and that until such a program is effected, your committee recommends that the resolution be not adopted.—JAMA, July 13, 1956.


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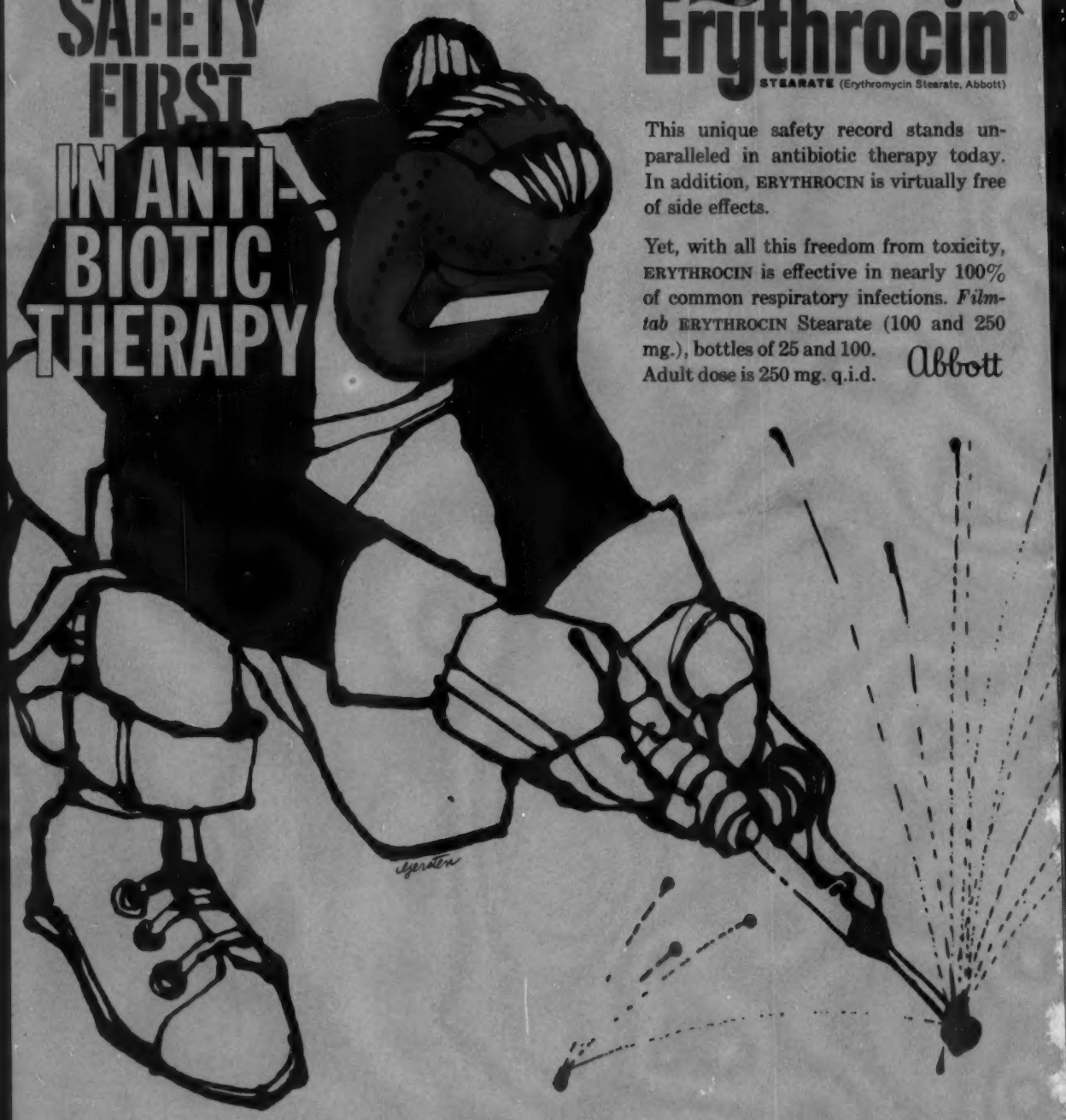

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Dosage: 1 or 2 teaspoonfuls t.i.d.

Supply: Bottles of 8 ounces and 1 pint.

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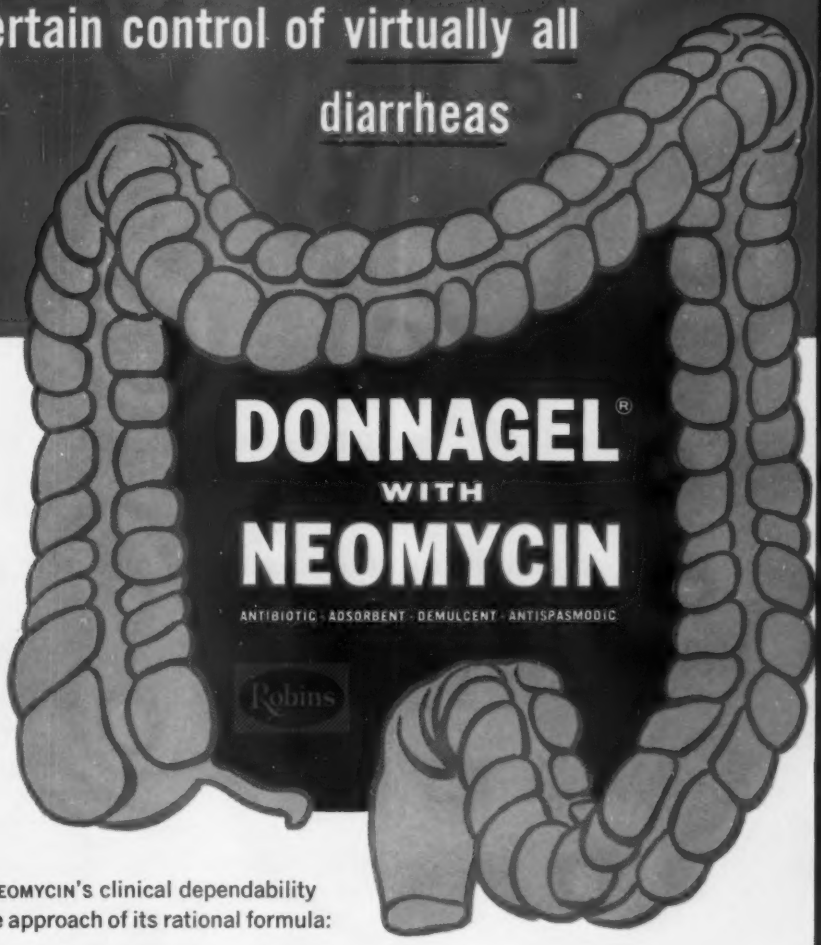

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Kaolin (6.0 Gm.)	adsorbent, demulcent	Binds toxic and irritating substances. Provides protective coating for irritated intestinal mucosa.
Pectin (142.8 mg.)	protective, demulcent	Supplements action of kaolin as an intestinal detoxifying and demulcent agent.
Dihydroxyaluminum aminoacetate (0.25 Gm.)	antacid, demulcent	Enhances demulcent and detoxifying action of the kaolin-pectin suspension.
Natural belladonna alkaloids: hyoscyamine sulfate (0.1037 mg.) atropine sulfate (0.0194 mg.) hyoscine hydrobromide (0.0065 mg.)	anti-spasmodic	Relieves intestinal hypermotility and hypertonicity.
Phenobarbital (¼ gr.)	sedative	Diminishes nervousness, stress and apprehension.

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Informational literature available upon request.

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tracheitis
ethmoiditis
streptococcal pharyngitis
nasopharyngitis
tracheobronchitis
bacterial pneumonia due to resistant pneumococci, staphylococci, or mixed flora
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875 patients showed an excellent or good response

38 patients had fair response

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References: 1. Case reports in the Pfizer Medical Department Files from fifty-three clinicians, and the following published reports: Shubin, H.: Antibiotic Med. & Clin. Therapy 4:174 (March) 1957. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. Winton, S. S., and Chesrow, E.: Ibid., p. 55. LaCaille, R. A., and Prigot, A.: Ibid., p. 19.

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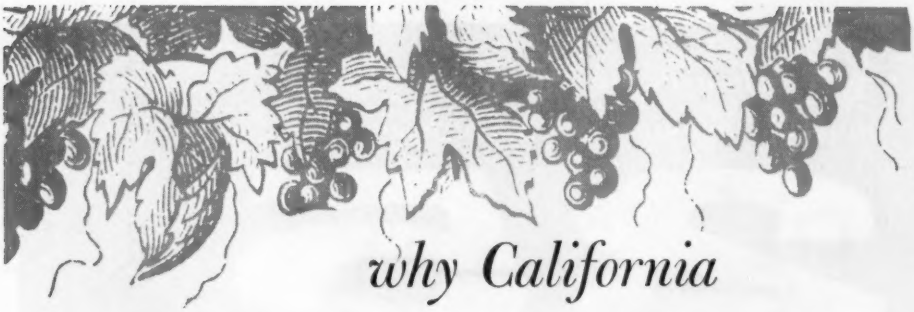

why California table wine in the low-sodium diet?

TABLE I[1]

	No. specimens examined	Sodium (mg./100 cc.) Mean
Musts (crushed white grapes)	9	1.63
California Red Table Wines	82	5.56
California White Table Wines	73	5.44
California Dessert Wines	104	7.10

*D*ietary restriction of sodium has become a standard procedure in the control of edema associated with cirrhosis of the liver, congestive heart failure, certain kidney ailments, toxemias of pregnancy, during digitalization and in drug-induced diuresis.

Unfortunately sodium-restricted diets tend to be flat, tasteless, monotonous, leading toward failure of dietary cooperation by the patient.

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In a recent study[1] it was shown that California table wines are remarkably low in sodium content—less than 10 mg. per 100 cc. (3½ ounce glass).

Since recent research [2,3,4] has also shown that wine stimulates a lagging appetite and aids digestion while adding a sparkle to any meal—why not encourage the moderate use of wine by the patient on a restricted dietary, as well as by the sufferer from anorexia, the post-surgical, convalescent or geriatric patient?

May we send you a copy of "Uses of Wine in Medical Practice"? A copy is available to you, at no expense, by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

1. Lucia, S. P. and Hunt, M. L.: Am. J. Digest. Dis. 2:26 (Jan.) 1957.
2. Goetzl, F. R.: Permanente Found. M. Bull. 8:72 (April) 1950.
3. Irvin, D. L. and Goetzl, F. R.: Permanente Found. M. Bull. 9:119 (Oct.) 1951.
4. Irvin, D. L.; Durra A., and Goetzl, F. R.: Am. J. Digest. Dis. 20:117 (Jan.) 1953.

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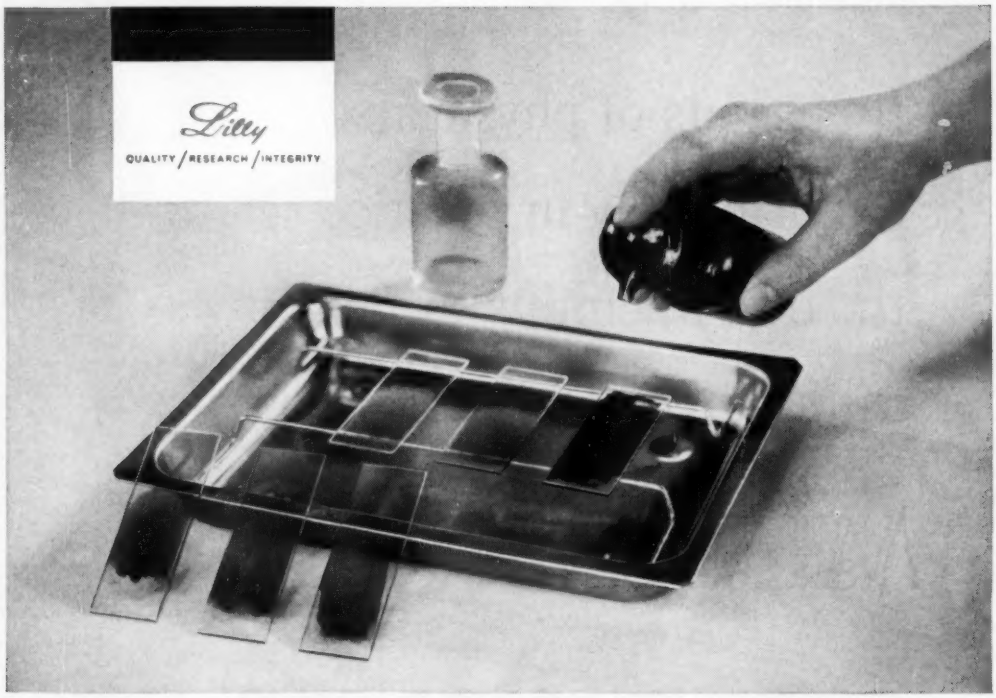

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The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 56 OCTOBER, 1957 NUMBER 10

The Kaleidoscopic Nature of Psyche and Soma

By Peter A. Martin, M.D.
Detroit, Michigan

THE TERM "psychokaleidoscopics" was coined by the author for this paper, in an attempt to emphasize the constantly changing combinations (like a kaleidoscope), of psyche and soma within each patient. Confusion as to how psyche and soma are related is not uncommon in medical practice. Psychiatrists frequently encounter two extreme attitudes in their nonpsychiatric colleagues. One is the attitude in which, in the absence of positive physical and laboratory findings, the patient is told by his physician that there is nothing organically wrong with him, so he must be neurotic and he is referred to a psychiatrist. This is an erroneous method of diagnosis of a neurosis by the exclusion of physical findings. The other attitude is a newer one, but one that is encountered with surprising frequency and appears to be a misguided offspring of the rising emphasis on psychosomatic medicine. It erroneously concludes that psyche and soma should always be considered as one, and thus *every* somatic illness is either partially or wholly due to psychologic forces. This view may result in a referral to a psychiatrist for total care of a patient even in the face of proven organic findings of a nonpsychiatric nature. As will be illustrated in the clinical material which follows, one-sided viewpoints can place the patient in a dangerous position.

Pertinent clinical material will be presented from the case histories of several patients. This material illustrates the kaleidoscopic nature of the human organism, and leads to conclusions about the danger not only of oversimplification of the relationship between psyche and soma but, also, the danger of complacency after establishing the relationship in a particular patient, in believing that it will continue thereafter unchanged.

Read at a meeting of The Michigan Society of Neurology and Psychiatry, Detroit, Michigan, March 21, 1957.

Case Reports

Case 1.—The first case is that of a twenty-eight-year-old white man who was transferred from the psychiatric section of a general hospital to the state hospital with a diagnosis of schizophrenia. His previous medical history was one of periodic episodes of vomiting for a duration of five years. During these episodes, he was unable to "hold anything on his stomach." According to the informant, no one was ever able to determine what was physically wrong with him. His last attack, which began with persistent vomiting and epigastric pains, forced admission to the general hospital. At the time of admission he was described as a person having many frends, being very sociable and always liked by people.

This patient was kept on the medical service for three-and-a-half months and given an intensive medical work-up to determine the cause of his pain and vomiting. His case record was thick with laboratory reports. The following is a very brief summary of his chart after months of hospitalization:

History on Admission: Persistent vomiting for one week—epigastric pain. No response to medical treatment. *Physical Findings:* Essentially negative. *Laboratory Findings:* Essentially negative. *X-Ray Findings:* GI series—No cancer, ulcer or vitamin deficiency. Steer horn stomach and possible gastritis. Barium enema—no pathology shown. IV pylogram — no pathology shown. *Gastroscopic:* poor emptying stomach—hypersecretion. Possible hypertrophic gastritis, pylorospasm or

pyloric stenosis. *Treatment:* Patient received atropine, phenobarbital, tincture belladonna, I.V. fluids, and vitamins. He showed no response to treatment and became progressively more depressed, withdrawn and resentful when told nothing was wrong with him. *Remarks:* "Patient completely washed up on medical service. Variety of drugs tried with no success."

Final Diagnosis: Vomiting—psychogenic in origin. Depressive state.

Because of the foregoing picture, he was presented at the psychosomatic seminar which was headed by a psychiatrist. There, a tentaive diagnosis of schizophrenia was made and a recommendation that he be transferred to the psychopathic wards. Following his transfer, he became more depressed and then frankly psychotic. He refused to talk to anyone for three weeks and, when asked why, told his sister that he thought his mouth got him into trouble. He attempted suicide because he was told that his vomiting was all in his mind. He then developed a mood change to one of excitement, in which he was very happy, cried, and believed that he would leave the hospital entirely well. These alternating moods of depression and excitement finally resulted in his commitment to the state hospital. His family did not believe there was anything mentally wrong with this patient and resented his hopitalization.

When admitted to the state hospital, he was despondent, apathetic, confused and disoriented. This picture, coupled with the extensive physical work-up he had recently had and his transfer diagnosis, caused him to be placed on electroshock therapy. He showed no response and continued his vomiting between such treatments. A steady downhill course necessitated sending him to the hospital ward where he expired six weeks after admission to the state hospital and fifteen days after his last shock treatment.

Following are the pertinent sections of the autopsy report: "The stomach, after evacuation of the contents, measures 29x16x2 cm. At the duodenal cap, 2 cm. from the pyloric ring, there is an old scar from an old peptic ulcer. This appears to be what has produced the chronic obstruction. There is no suggestion of malignancy and the stomach appears to be in fairly good condition except for the enormous distention. There is no evidence of active ulceration. The hepatic duct is involved in the scar tissue. . . . Cause of death: pyloric obstruction."

Careful re-examination of the entire case history of this patient led to these conclusions. The underlying schizophrenic potential broke through under the stress of his disheartening prolonged hospitalization. If surgical intervention had taken place, both his psychosis and his death could have been prevented. This man died because of the lack of recognition of these principles: (a) Referral from competent medical men does not rule out organic illness. There is an increasing collection of literature to verify this conclusion. (b) The presence of obvious mental illness does not prove it to be the cause of any physical symptoms present. The psychotic picture was accepted as explanation for his vomiting. His symptom complex was considered to be a psychosomatic one. Actually the preterminal picture was a somatopsychic one.

Case 2.—This patient was a fifty-five-year-old white woman brought to the hospital from another mental hospital where she had just received seventeen electroshock treatments. Her diagnosis was paranoid schizophrenia. She still had auditory hallucinations with paranoid delusions on admission. In adition, this picture was complicated by the marked type of confusion which often accompanies electroshock. The psychiatrist's admission examination indicated necessity for a further intensive physical work-up. A referral to an internist consultant resulted in the diagnosis of myxedema, mixed with multiple gland deficiency. Subsequent inquiries into previous medical illnesses revealed that the history of previous recognition of this organic pathology had been ignored by the psychiatrist who gave her shock therapy. Her basal metabolic rate was —21. Stomach contents revealed an achlorhydria. The internist consultant placed her on thyroid, pituitary extract, lextron and acidulin. The daily change, though gradual, was dramatic. The psychosis cleared up as her physical condition improved. She was discharged in four weeks after onset of medication.

The second patient like the first had an underlying psychotic potential. The paranoid psychosis broke through with the organic trauma of the severe hypoendocrinism. The hypoendocrinism precipitated but did not cause the psychosis. The psychosis did not cause the hypoendocrinism. These mutually exclusive entities were interrelated, but not as cause and effect. In the presence of malfunction of physiologic activities, healthy ego defenses failed.

Case 3.—The third patient in this series was a forty-seven-year-old white woman who was admitted to the hospital where her husband had undergone serious abdominal surgery. She was described as having made a nuisance of herself at the hospital by doubting the efficiency of the nurses and the doctors and fearing her husband would die. For this reason, and in order to prevent disturbing the husband's convalescence at home, his surgeon sent her to the private mental hospital for observation. A careful psychiatric evaluation revealed considerable stress at home but, on the basis of the examination, the psychiatrist could positively state that she was neither psychotic nor neurotic. Her medical history and examination indicated some physical disorder present and she was referred to the consulting internist. Following is a portion of the initial report: "From the clinical standpoint, she has a chronic bronchitis and possibly a chronic cholecystitis. I would

recommend a gall bladder series for the latter. There is no explanation for the high leukocytosis (17,000) at present." Chest and gall bladder x-rays were negative. Leukocytosis persisted despite a course of penicillin. The consultant then ordered a gastrointestinal series, which revealed a questionable lesion in the stomach. She was then referred to her own internist for definitive action. He ridiculed the need for surgery. The psychiatric team, then, had to insist upon gastroscopy. Through the latter procedure, a small sessile polyp was visualized. The psychiatric team insisted on surgery, despite objections of her internist as to the benign nature of the lesion. This resulted in partial gastric resection and posterior gastrojejunostomy. Portions of the biopsy report follow: "The biopsy of the gastric mucosa shows marked lymphocytic and plasma cell infiltration with some polynuclears. There are areas of atypical glandular hyperplasia with mucin formation. In some areas this appears to be a small benign adenoma but where there is evidence of infiltration, the tumor is evidently an early adenocarcinoma arising from abberant tissue."

This paper is written eight years after surgery and the patient has been in good health, both physically and mentally up to the date of this follow-up study. An eight-year cancer cure of the stomach has been achieved. A psychiatrist's diagnosis of no mental illness has been confirmed.

Case 4.—The fourth case is that of a middle-aged man who suffered from severe frontal headaches for many years. He had repeated medical examinations but no cause for his headaches was discovered. At one large medical center, he was finally scheduled to be examined by a psychiatrist. There, after a half hour of questioning, he found himself denying the psychiatrist's repeated allegations that his headaches were due to his hatred against his father. Finally the psychiatrist heatedly said, "How can you say you don't hate your father when you told me he was a beggar?" In horror, the patient who spoke with a New York accent explained to the midwestern psychiatrist that he had said his father was a "baker" and not a "beggar." His headaches continued unabated by this interview.

The patient's wife was a person who had phobic reaction to doctors. So, when his wife had to see an ear, nose and throat specialist, he said he would go and be examined first in order to get her to the doctor, and also in a vain search for relief from his headaches. Upon examination, he was told that nothing was wrong with him except for a slightly deviated septum, but that his wife needed immediate surgery for nasal polyps. In order to overcome her neurotic fear, he offered to go into the hospital for surgery on his deviated septum at the same time as she would have her polyp surgery. At his operation, when the nasal septum deviation was removed, a large soft tissue tumor occupying the frontal sinus was exposed and removed in its entirety. His headaches disappeared forever after this surgery. However, his wife complained for weeks after surgery about pain and discomfort in her nose. The surgeon said that he could find no reason for it, that surgery had been successful and it must be an emotional reaction in this neurotic woman. Fortunately, her symptoms disappeared a few days later when a nasal pack which had been left in at surgery dropped out unexpectedly.

The shifting conditions of psyche and soma are clearly illustrated in this last case history. These kaleidoscopic pictures need frequent reviewing in order to see what changes have taken place. Oversimplification or one-sided viewpoints are dangerous to the patient. It would take a mathematician to work out the number of combinations of psyche and soma that the physician should look for. Just a few will be listed here: (1) A somatic illness with minimal, mild, or moderate or severe emotional reactions to it; (2) an emotional illness with minimal, mild, moderate or severe physiological reaction to it; (3) a somatic illness and an emotional illness present at the same time but not related as to cause and effect; (4) an emotional conflict leading to an organic illness which leads to the development of an emotional illness not directly related to the original emotional conflict.

Summary

The author has attempted to illustrate clinically a few of the many varying relationships between psyche and soma which may occur in any patient. It emphasizes the need for continuing evaluations of these relationships in all patients.

Forty per cent of patients complaining of postmenopausal bleeding have cervical carcinoma.

* * *

The treatment of cervical cancer is largely irradiation therapy and should be given in centers properly equipped to give radium and deep x-ray therapy.

The treatment of endometrial carcinoma is a combination of irradiation and surgery.

* * *

Bleeding should never be ascribed to a benign cause, such as a cervical polyp, until curettement has ruled out endometrial carcinoma.

Clinical Manifestations of Anxiety

By Peter A. Martin, M.D.
Detroit, Michigan

THIS paper will be directed primarily to the presentation of the clinical manifestations of anxiety; however, to avoid the lack of understanding that results from pure description, theoretical assumption will be continuously interspersed. We will start with the picture of the fetus *in utero*. In this veritable paradise, the fetus is subjected to a minimum of stimuli, a minimum of activity, and a minimum of unpleasure. But at birth a marked change occurs. Paradise is lost. Instinctual needs are no longer being automatically and continuously gratified. The newborn is introduced to loud noises, bright lights, and to the need to breathe for itself and to actively participate in its own nourishment. At birth we can observe the muscles of the infant's face contorted, as if in pain, we can observe undirected muscular discharges in the extremities and we can hear his disturbed cries. What we are seeing is a disruption of homeostasis. This is a diffuse dystonic reaction to a disturbance of inner equilibrium. Subsequently, a similar total and overwhelming reaction involving the entire organism occurs whenever an infant's homeostasis is disturbed by intense hunger, thirst, inner discomfort or outside stimuli that interfere with its balance. We cannot know directly what the precise qualities of the emotion experienced by the infant are at this time. However, we can say that at this early stage, the infant experiences unpleasure due to a mixture of several affects, prominent among which is the forerunner of anxiety.

Let us carry the infant a step further. Let us suppose he has succeeded in mastering the art of nursing. He has experienced the gratification and satisfaction of his hunger pains, the change from unpleasure to pleasure. His stomach does not know that mother has been instructed to place the infant on a rigid four-hour feeding schedule. His pangs of hunger may become severe in three hours. During the one hour's wait until mother feeds him, he experiences an accumulation of unpleasant stimuli against which he is powerless. Manifestations of anxiety develop in response to being so overwhelmed. The establishment of anxiety results from the infant's biologic and psychologic inability to cope on his own with the increase of tension arising from nongratification of his needs. This disturbance of homeostasis is experienced as a threat to his existence and, in reality, this is so. If uncared for, the human newborn dies.

As the growing infant's experiences increase, and his other ego functions develop, such as memory and sensory perception, the child becomes able to predict or anticipate that a state of unpleasure will develop. For example, his first pangs of hunger at the three-hour mark, though mild may be a signal to touch off a severe reaction in anticipation of a repetition of previous severe discomfort.

We can now define anxiety as it will be used throughout this presentation. Anxiety is an unpleasant emotion or affect which is evoked by the anticipation of danger. It serves a function of being a signal of trouble to come, trouble to the extent of possible annihilation. But anxiety is not only a psychic phenomenon. There are, as mentioned, physiological expressions which are adrenosympathetic. These *anxiety* equivalents are characterized by an increase in the cardiac and respiratory rates, and by gastrointestinal hypermotility, by a rise in blood pressure and changes in the vascular system throughout the body. The physiologic discharge phenomena form a syndrome which can be studied objectively and which is constant from individual to individual. These visceral responses change very little after birth except that they acquire a somewhat favored localization in one system of organs. One person may react more intensely by cardiovascular, another by gastrointestinal, and a third by respiratory system reactions. Chronic effects of anxiety form the basis of so-called pschosomatic conditions. Probably the localization is due to an infantile trauma

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and fixation, with some hereditary factor.

In the adult, the cardinal feature of anxiety is its vagueness. This quality characterizes both its affective or feeling aspect and its expressive aspects. The *affect* of *anxiety* is perceived as an uneasiness of varying degrees of painfulness and pressure, together with a quality of uncertain foreboding. The expression of anxiety includes diffuse activity from mild excitement to extreme restlessness. But, like its affect, the activity is objectless and undirected. Extraordinarily alert and expectant, the anxious individual is ready to adapt to changes in the outer situation.

The wide range of responses to anxiety is well known. For example, mild anxiety is felt in reading stirring passages of a book, or just before the trigger is pulled in hunting. At such times, the person is on the alert, with no definite purpose other than the most general one of being ready for anything. Similar reactions, but with greater urgency and restlessness, occur in more disturbing situations. Extreme degrees of anxiety, apparently out of proportion to the external stimulus, occur among neurotic and psychotic individuals. Normal individuals, under marked stress, as in war, can experience regression to extreme anxiety. This may appear when the stimulus is great, sudden and overwhelming. A sudden exposure to great danger catches the organism unaware and unprepared. The widespread diffuse paralyzing reaction of disorganization is known as shock or panic. Rational conduct is paralyzed; fragmentation and shattering of habitual reactions occur and there is regression to infantile reactions. The individual is said to "lose his head" or "go to pieces." Inhibitory learned processes are detached and the person says and does things that under normal circumstances he would avoid. Prolonged states of anxiety may occur in continuously difficult situations which cannot be resolved, such as the maladjustment of some men in military service. Free-floating anxiety with no apparent cause results from unconscious conflicts.

The above description gives the more obvious manifestations of anxiety. There are also hidden manifestations of anxiety as seen in the character of an individual. To illustrate the latter, let us return to the picture of the infant. The days following birth are indeed difficult ones. Even under ideal circumstances, the infant is faced with unavoidable frustrations to which he responds with intense undifferentiated affects and physical discharges. At first psyche and soma are one. Any psychic trauma has a somatic discharge. Any somatic traumas leave psychic impressions. Disturbances in the infant-mother symbiotic relationship in the first few months lead to anxiety resulting in feeding problems, colic, diarrhea, constipation and what may be the anlage of the psychic components in psychosomatic disorders, such as peptic ulcers, asthma and ulcerative colitis. Increased frustration of essential instinctual needs abnormally increase the amount of anxiety with deleterious physical results. Motherly affection during this period is an essential need, and infants who do not receive it may react with mirasmus and die despite adequate nourishment.

At six months of age the first deciduous teeth erupt. The infant then has his first and most powerful weapon. If he becomes frustrated, he may respond by biting the offending parent. Mother may punish him or speak crossly to him. This feels dangerous. He develops anxiety.

When he starts to crawl and to investigate, he may be hindered by unwelcome restraints. He is forbidden to touch, to sample, to destroy, to soil, to slap, to kick, to scratch, to bite, to spit, to suck, to scream and so on *ad nauseum*. But he learns that if he expresses his mental or physical nausea, Mother withdraws her love. This is dangerous since he is dependent upon Mother for his life. Both birth anxiety and the anxiety of the infant alike claim separation from the mother as their prerequisite. This fear of separation can occur in thousands of minor experiences like the ones given above.

Let us take another common example of an anxiety provoking experience: rivalry. The old problems of Joseph and his brethren, sibling rivalry, frequently disrupt the peace of the home. Also, the child is jealous because his parents love one another and because they love the other children. The child wishes to be the one and only beloved of his mother and father. When the new baby is born, the child often says, "Send him back. We don't want him." Or the child awaits an opportunity to hit the new infant. Or the child may attempt to destroy the sibling by pushing him down the stairs, hanging him on the clothes line, sticking a nipple down his throat, or feeding him poison tablets from the medicine chest. These are but a few examples from real-life experiences.

Jealousies between fathers and sons and mothers and daughters are important producers of much anxiety. This anxiety is an expression of the fear of separation from the parents. What then does the child do with all this anxiety? It is too painful to live with.

The child may transform the anxiety by one of several mechanisms:

1. Perhaps the child avoids the anxiety completely by developing "good boy" character traits. He may become overly kind to the younger sibling whom he hates or overly admiring of the father whose tyranny he cannot stand. He becomes gentle, shows horror of violence and great solicitude for the supposed loved ones. He can't stand the sight of blood, or vomitus or feces. He may become teacher's pet. Under the calm exterior, the anxiety will short circuit elsewhere—migraine, colitis, hypertension, polyuria, diarrhea.

2. Pehaps he does not disguise his reaction to prohibitions completely, but may redirect them from the parents to people of lesser importance or to inanimate objects. He may kick the dog, beat the cat, break his toys or pick a fight with a smaller neighborhood child. He may spit at strangers or throw rocks at passing cars. The relief in family tension is offset by negative attitudes to people outside of the family circle. As he grows he continues to behave in the pattern established when very young. He may continue to be destructive and cruel, to fight, to bully, to lose his temper. He may later express hostility to teachers, employers, wife, husband, child or anyone with whom he feels he can get away with it. Attitudes such as these are not reversible by experience, because they are anachronistic. They are not based on what the teachers, employers, really are like, but are based on the displaced hostility from the authoritarian figures of the nursery years. Such a pattern is responsible for much of the strain, suspiciousness and intolerance in the relationships between individuals and nations. Sissy and bully are common patterns.

3. Perhaps the child eliminates anxiety by projecting unacceptable feelings outward. They cease to be felt as part of the child's inner world and are ascribed to persons or things in the external world. One example was the concern of a mother over her three-year-old who had developed a fear of having a bowel movement because she was terrified that the movements would bite her. This caused frequent trips to the lavatory with no results. We worked this problem out successfully, because we came to understand that the child was feeling anxious because of hostile feelings to the mother at that time and in an attempt to deny these feelings and avoid further anxiety, projected her desire to bite mother out on to the bowel movement and substituted herself as the object of the biting. Another example is the mother who became upset because her child became terrified of her and claimed that mother was going to hurt her despite vigorous repeated denials by the mother. The mother had previously been the object of much affection from the child. But mother had gone away on a trip. This aroused separation anxiety. The sudden change in the child was an attempt by the child to feel safe by projecting her resulting hostility on to the mother. By putting the mother in the role of aggressor and persecutor, she disguised her desire to hurt mother. These similar ideas and mechanisms are seen in the mentally ill adults. They are seen in paranoid personalities and in paranoid schizophrenics who have delusions of persecution and auditory hallucinations of a persecutory nature.

4. Perhaps the child avoids his anxiety by turning his hostility in against himself. He becomes furious with himself and feels wicked and shameful. The harmful consequences are manifold and are expressed by a heightened inclination to develop organic illness, a tendency toward frequent harmful accidents, and in the mental sphere as manifestations of an overly strict conscience, as in the depressive states.

A man reported a clear-cut example in his own child. Each evening at the dinner table he had brought verbal pressure on her because she was not eating well and finally he had threatened punitive action. The next evening just before dinner time she made what was for her an unusually clumsy movement, fell over the dog and hit her front teeth on a chair. Without crying she arose, sat down at the table and announced that she couldn't eat because she had hurt her teeth. Thus the child avoided anxiety by turning her hostility inward against herself—punishing the teeth with which she was desirous of biting her father and at the same time conquering the situation through self-inflicted injury.

5. Perhaps the child's anxiety doesn't develop,

(Continued on Page 1265)

Psychological Medicine

By John M. Dorsey, M.D.
Detroit, Michigan

Self Consciousness vs. Self Hypnosis

"A dangerous tendency is to such a limitation to a speciality as will lead to withdrawal from the common interests of the profession. A medical specialist should not thereby, in his sentiments and conduct, be any the less a physician; the honor, dignity, and usefulness of the profession, as a whole, should be as sacred in his estimation as if he were not a specialist. If the effect of specialism be otherwise, alas for the medical profession of the future, as regards the respect of others and the self-respect of its members!"

AUSTIN FLINT[1]

THE FOLLOWING venture in medical realism is one which I find helpful. At first reading, one or another of its self-observations seems pretty high-up, although none is, or can be, over my head. May it awaken an able mind to the important task of a weightier and more attractive presentation of medical psychology as being the physician's study and practice of medicine in his mind. The more every physician lives himself consciously the more he grows a wide awake view that his whole "world" is all his, his world which he grows within himself as a creation of his own mind. Seeing that every meaning of health and of illness has a psychologic existence, he develops the insight that it is profitable for him to study and practice himself as a psychologist in each activity of medicine.

In his charming witty address "Careers In Medicine," Dr. William Bennett Bean, State University of Iowa, comments sagely upon "the splintered subunits of medicine" now tending to alienate one specialist from another, as well as physician from layman. In his conclusion he says, "If he achieves intellectual honesty, the physician is beholden to no man, no political group, no industrial machine."[2]

Dr. Austin Smith, Editor, *Journal of the American Medical Association,* counsels the men and women "who cherish the letters 'M.D.'," upon the importance of the "attitude of mind." He asserts that, "the future can be made secure only when truth, fearlessness, respect, and perseverance dominate the actions" of every physician.[3]

This particular autobiographical sketch intends as fearlessly as possible to extend my concept of my full wakefulness to mean only waking up to myself, so that I shall see all of my medicare as self-care. Although the "individual variant" has always represented the basic orientation of the doctors of medicine, in the name of Aesculapius, why is it that radical individualism, implicit in the self-evident truths that every patient must restore himself to, and maintain, his health, has not been sufficiently a serious medical position?

The person of hysterical character, who caricatures the self-development of the mature person, depends for his "show" of living upon the illusion that "somebody else" can be conscious for him. Thus his system of psychology depends upon his illusion of being "in the lime light," "up stage," "front and center," and so on, without "stage fright." "Stage fright," or "buck fever," is the product of a self consciousness which is capable of only a restricted range of selfhood. The "hysterical" one has no insight that all of his apparent "between-ness" is really within-ness, or that his apparent use of his language for "communication" is really a soliloquizing. The hysterical character closely precedes the mature character in point of psychogenesis, hence its creator may succeed in taking himself for mature mental development. The mature minded one, however, aware that all consciousness is self-consciousness, that "grand standing" is self-ignoration, readily renounces living "for the gallery" in favor of the full joy of living inherent in his calling his soul his own and seeing his own soul in all of this living.

Any part of my living which I cannot consider my own, and, therefore, which I must live as if foreign to me—all such made unconscious force in my life does not thereby become inactive. Far from that, it functions on as an obstruction to my harmonious existence. For instance, all of my

From Wayne State University College of Medicine.

"not-I" living, which I cannot see as my very own, enforces an obstructive psychology, necessitates great disorder of my human economy, uses up my energy for purposes of maintaining my self deception, and makes me generally live myself as if my individuality is not intact.*

When I am able to use this kind of self-insight I am able to see that my ailing world is in constant and urgent need of medically esteemed and regulated psychological medicine. The opiate of self-unconsciousness develops the most injurious of all addictions. The health indication for my assessing myself as a psychologist presents itself insistently whenever I observe that every phase of my medical work involves nothing but my use of my mind. All of my "doing" is really my minding, or mental doing, which is mostly unrecognized as such. It is my living only which can "make." My life makes what I "do."

As a physician of any division of medicine, my only question about using psychological medicine is whether I shall employ psychotherapy consciously, that is, in a way in which I can voluntarily control its dosage, or unconsciously, that is, in a way in which I leave its dosage largely to my patient's decision, or to my other unconscious forces sometimes conveniently summed up in the word "chance."

The Study and Practice of Medicine in Myself

"The eyes of the dead are closed gently;
We also have to open gently the eyes of the living."
COCTEAU

The psychical work of delicately opening my mind's eye to be able to see that every "fact of my immediate experience" is nothing at all except a sign of my own living, to be able to discern that I show "signs of life" by just such self growths as my sensations and perceptions—this human exertion may well be described as a process of "making my self conscious," so that I can escape fixing my life and self esteem on some lower round of activity. Nowhere can I suffer more from arrest of development than in my self-awareness! Nowhere can I enjoy more the momentum of progress than in extending my conscious self-tolerance. What else can my external "observation" be other than a creation of my introspection!**

I consider that the culmination of my personal, including professional, development occurred when I grew strength of mind sufficient to diagnose myself as a patient, a psychiatric patient, suffering both from mental weakness and mental illness, and thus became able to devote myself continuously to the strengthening and healing of my mind. Before I was unable to diagnose my way of living myself as being ill, I was unable to consider treating myself well. As Dr. Alfred T. Schofield noted, "Is it not extraordinary what value the public attach to such a trivial matter as 'cure'; and yet how utterly incapable they seem of grasping the importance of 'diagnosis'? A sage M.D. sees his professional role as a medical psychologist, a psychological physiologist. He observes that the removal of psychology from any medical work leaves nothing, that a body without a mind is dead, that life without mind is life without meaning. He will find himself striving to see to it that every one of his fellow physicians in organized (integrated) medicine is alerted to the comprehensive meaning of psychological medicine.

It is not hard to trace the origin of any physician's uncertainty as to whether or not he is entitled to regard himself as a professional medical psychologist. From his earliest years he may have enjoyed little or no opportunity for disciplining himself to look to his mind as the source of his vitality, or even to observe the living of his own creaturehood in the workings of his mind. His early schooling may not have served as a means for his observing his education, or learning, to be nothing but an expression of his self-growth, nothing but his very own mental development. Even in his medical school living he may not have trained his mind to observe the various data of his several medical disciplines as being nothing but psychological data, entirely self-discoveries constituting the building of his very own medical character. Chances are he may have kept himself so busy "learning the facts" about what he called

*Professor Walter H. Seegers, Chairman of Wayne's Department of Physiology and Pharmacology, pays due attention to the physiological expressions of clear and obstructive psychology in the training of his student in integrative physiology.

**McGregor Center is a small thirty-three bed general hospital used by my department faculty as a training center where my medical student may observe in practice the therapeutic force of medical concentration upon self-reliance, self-help, self heal, self recovery, and self esteem which includes feeling grateful to one's self for the self power enabling all such self control over one's health interests.

"anatomy," "physiology," "chemistry," "psychiatry," and so on, that he forgot the only truth of the matter, namely, the one fact of his own development as a medical student. If in one or another part of his curriculum, he did have the opportunity to study his school work as being entirely his own self-growth, the rest of his medical school living may have favored his mental dissociation to an extent calling for, but not receiving, his giving himself the one psychiatric treatment efficacious under the circumstances, namely, restorative self-consciousness. Every medical student's life creates and controls all that he lives. His medical school lives in him, not he in his medical school. His life contributes all of the possible meaning his professor or his textbook can have. His life-force is all that can possibly have any basic meaning to him, or create any auxiliary meanings for him. His vitality is his *vis medicatrix naturae*. His four years of living his medical school are best devoted to his finding out in a self-reliant way the true wonderfulness of himself as a human being, his marvelous powers as an individual, his unique vital force as a person. Can it be that his present opportunity to discover his potential strength by training his mind in the way of medical living can be improved. As William James observed, for an empiricist every difference must make a difference.

Happily any kind of unconscious medical school living, requiring the medical student to work his head "off" instead of on, "the morbid pursuit of health," has been yielding place to the living of safe and sane medical education recognizable as self-activity. The picture is a cheerful one. The veteran practitioner has grown the insight that he is a medical psychologist, in the unfailing school of personal experience; the recent graduate has methodically trained himself as being a medical psychologist. It is only the remaining practitioner who discovers to his surprise that his patient's mind is crying for a relief from a specific kind of disregard clearly definable as self-hypnosis. Nevertheless, this brother physician may sense his own unpreparedness to mind, to care for, himself as a medical psychologist. He cannot recognize that self-consciousness is truly the healthy exciting enlivening, yet tranquilizing force which it is, particularly if he has had the soporific habit of mind which associates the use of self-consciousness only with the production of pain and of self-unconsciousness only with the alleviation of pain. He can help himself tremendously with the discovery that self-consciousness is such a life necessity that if a child cannot live it self-reliantly he must have his "somebody else" live it for him (by "attention seeking"), and that his patient, overwhelmed by stress of suffering, invariably regresses to this "childish" way of expressing his need to live more of himself as worthy of consciousness than just his complaints.

It is this latter physician particularly who may appreciate finding in his own medical journal recurring considerations on psychological medicine. He is an earnest sincere practitioner who, recognizing (1) the extremity of his patient's need for mental support, and (2) the dearth of specialist psychiatric helpfulness in his community, may turn to some professional man, not a physician, as possibly able to supply psychological medicine. Although I feel certain that no one who is not a physician, and who knows what he is doing, would find it possible to assume, or usurp, this life-and-death kind of responsibility, or would consider medical work for which he is untrained to be a welcome opportunity for him, nevertheless it is readily conceivable that many a well-intentioned nonmedical man may get himself into this kind of serious trouble without realizing its full extent.

Any and all prevailing illusional views of what constitutes, or shall constitute, the legal practice of medicine, may be seen as of health account, in calling attention to the clear picture of the necessity for the study, as well as the practice, of medicine in one's physician. I may be intolerant of my brother physician's disregard for his force of mind as a tremendous medical force, but I will not expect my brother layman to assume that professional prerogative. Likewise, my brother physician will not expect his brother layman to practice psychological medicine in himself before studying it. That is, he will not expect such an accomplishment once he recognizes its full implications. The very idea of a layman undertaking "wild" medical work must be one for every physician to renounce kindly and firmly, realizing as he does the innumerable and inevitable life risks involved in his own medical living. Is it not likely, however, that neglect of the conscious use of the mental force by the doctor of medicine necessarily encourages its conscious use with medical intention by others?

The Legal Practice of Medicine

Nearly half a millennium B.C., Socrates came back from army service to report to his Greek countrymen that in one respect the barbarian Thracians were in advance of Greek civilization: They knew that the body could not be cured without the mind. "This,' he continued, "is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole.' It was Hippocrates, the Father of Medicine, who said: "In order to cure the human body it is necessary to have a knowledge of the whole of things." And Paracelsus wrote: "True medicine only arises from the creative knowledge of the last and deepest powers of the whole universe; only he who grasps the innermost nature of man, can cure him in earnest." To us today this seems rather an impossible demand.

FLANDERS DUNBAR

Who should practice psychotherapy? How should undergraduate medical training represent psychiatry? Should this training even consider psychiatric education as a separate discipline apart from every other kind of medical training? May not such a first view of psychiatry, as being isolable from other medical interests, be an unrecognized basis for a physician's later dissociation of psychotherapy from "other" medical and surgical diagnosis and treatment? Ought not undergraduate medical training be aimed at the development of every physician as a psychotherapist, not at interesting a few students in "going into psychiatry as a specialty?" May not this recognition of the mind as living itself in bodily ways, as giving the only meaning to "body" that body can have, provide a greatly needed insight for the health education (preventive medicine) program? May not the servant of the poor in health, the attending physician, attain his full therapeutic power in discovering that healthy self-esteem is the product of extending self-consciousness, quite as unhealthy self-disesteem is the product of ignoring the greatness of one's own being?

As a student of psychological medicine for some thirty-two years, I see clearly its present development, hence future achievement, to be centered in the mind of every physician. *May responsibility for being a medical psychologist, a student and practitioner of psychological medicine, be either in the consciousness or on the conscience of each and every medical practitioner.*

The interest of every one of us is now properly excited by a question frequently raised: What shall constitute the legal practice of medicine? Surely this is a question to which every medical educator, each qualified doctor of the profession of medicine, wishes and intends to see the clearest answer. It is also understandable that he views this question as one which cannot be answered without the voice of the physician himself. As a physician he respects the law of his land as authoritative in deciding what shall constitute the legal practice of medicine. He knows from his own personal experience what it means to grow himself as a physician, licensed to practice his profession. He has discovered many of the innumerable personal risks involved in his pursuing his medical way of life. He has grown a healthy respect for such medical meanings as "symptom," "complaint," "protest," "suffering," "early signs of serious disorder," "growing pains." His helpful sincere hopefulness and watchfulness are lived in terms of potential awareness of serious trouble, of grievous health risk, of unhappiest living.

Every physician's view as to what constitutes the legal practice of medicine contains the keenest appreciation of the nature of the privileges and responsibilities inherent in his professional work. He regards his medical living not only as a source of his livelihood but also as the source of his life itself, as devoted to cherishing and furthering the liberty and happiness inherent in healthy human development. He cannot abdicate his physicianship to anyone of his fellowmen who is not a physician, on account of the simple fact that he has personally grown his own insight as to what constitutes the privilege and responsibility spelled out in the words "The Legal Practice Of Medicine." He sees that violation of "medical practice" might be attempted but cannot be perpetrated, any more than the passing of counterfeit money can succeed in making it legal tender. The unique specificity implicit in the study and practice of myself in medicine is factual and inviolable insofar as my qualifications meet all of the professional, including legal, requirements involved. I can conceive of no worse predicament for anyone than that of taking upon himself the responsibility for being a physician without having the proper medical and legal qualifications for it.

It is to the credit of every American that every citizen's demand for proper health care has been steadily on the increase. As respect for the dignity of individuality grows in every citizen, certain of his rightful needs are bound to be sensed by him as properly insistent upon attention. One of these is his right to educate himself, another is his right to secure his health, prevent illness and accident,

and recover himself from any kind of disorder. The American physician gladly sees his fellowman exercise this right, recognizing it as basic for his pursuit of life, liberty and happiness. This same physician recognizes the need for many more trained medical personnel, just as he is painfully aware of the critical risks involved in the licensing of inadequately trained medical workers, not to mention the actual harm involved if a nonmedically trained one independently assumes medical responsibilities.

Health benefit, the opportunity for wholesome self-help, being the first concern in the mind of every American citizen, it is only prudent for him to safeguard by law what shall constitute the practice of medicine. Every physician recognizes that his fellow citizen is entirely free to help himself in every matter pertaining to his health. How he shall help himself is also a matter of his free choice. Every physician realizes that it is up to every citizen to treat himself well, in a way which will not interfere with his fellow citizen's treating himself well. Every doctor of medicine, in studying and practicing himself in his own chosen profession, cherishes his fellow citizen's right to take care of himself as best he can. *Caveat emptor* may appear to be a weak warning call which seems to abandon the buyer in an open market, but that is only a seeming. It is in truth a proper watchcry of the deeply concerned medical educator. Conscious freedom of individuality, including his health interests, is an indispensable basis for every one's progress in health and strength.

In a comprehensive sense, a person treats himself in numerous ways which he considers being "good for his health." For instance, all of his formal education may be conceived as education to health, and all of his religious living may be similarly considered. His "job" may be seen as occupational therapy. Even his climate has this health value for him, and so on. In appreciating all of the various ways in which his fellow man can help himself to strength and health, the physician has never in any way attempted to monopolize health helpfulness. His medical profession has succeeded on account of the fact that full respect for the total human individual is the basis for all of its work. However, as a layman, and as a physician, it is his civic duty to uphold what he regards as opening, and renounce what he regards as impeding, the way of health.

All of Medicine is Psychological Medicine

> "What unsatisfactory cases these are! This clever charming, and widely known lady will some day disgrace us all by being juggled out of her maladies by some bold quack who by mere force of assertion will give her the will to bear, or forget, or suppress all the turbulences of her nervous system."
>
> Sir James Paget, 1866

In this brief article it is possible to report the basic meaning of psychological medicine. In the first place this kind of self-discipline involves the physician's systematically aiming at viewing his patient as a part of his own living. In order to treat my patient as myself I have to be able to be conscious of a sense of my identity, a sense of living myself, in all that would be traditionally known as "the patient's living." For me, observing my patient is a matter of growing my perceptions and my sensations which I personify as my patient, a matter of regarding a series of perceptions and sensations of mine as "my patient." I do not, as the saying goes, "put myself in my patient's shoes," or have my patient "put himself in my shoes." Quite the contrary my patient is to be cherished in terms of all of his (my "his") individuality. For instance, just as I see my patient as a living part of myself which I call my patient, similarly I see my patient as living a part of himself which he calls his own physician.

In my study and practice of psychiatry in myself I renounce the pleasing view that I can help my patient, but I claim the more gratifying view that my patient is able to help himself. Thereby, I observe in action the vitalities of all healing, or virtue, in the simple heart of selfhood. My patient's realization of his ability to help himself is an invigorating one, contributing to his proper sense of self-esteem. By treating my patient as a part of myself I insure humaneness, kindness, in my every medical procedure. Psychological medicine is a modification of the Golden Rule. I do unto myself as I would have my patient do unto his self. I remain aware that I am self-contained in my living of my patient, renouncing every temptation to live myself as if I could be "out of my mind" and getting at a life other than my own.

Any and every way in which I live myself is a development of my individuality, a growing of my personality, which has any and every meaning for me only in so far as that meaning exists in my mind. What does my nourishment, or my medication, or my operation, or my patient mean?,

is the same as asking, how am I living each of those meanings? Awareness, or lack of awareness, changes the meaning itself no more than does my liking or disliking it. However, awareness does reveal each meaning as my own to care for. "I hate to admit it but it's true," is a viewpoint associated with all psychological "growing pains."

All Data Are Self Data

> It has been asserted, by one who was laboring under mental derangement, that the only difference between the sane and the insane, is, that the former conceal their thoughts, while the latter give them utterance. This distinction is far less erroneous than might generally be supposed, and is not destitute of analogy to the remark of Talleyrand, that "language was invented for the purpose of concealing thought."
>
> PLINY EARLE*

Depending entirely as it does upon my human system for all of its meaning, my system of pedagogy may best be described as psychagogy, as made up entirely of selfness. The term psychic, or mental, is not a term parallel to "physics," or "material," but rather is a meaning which subsumes all meaning.

It is well to observe that the statement, "I am my only reality," is not simply a restatement of a dogma of philosophy known as "psychic monism." My consciousness of my oneness, individuality, is not a product of theorizing, hypothesizing, philosophizing, but of psychologizing, of using self-observation. My appreciation of myself as an individual is not based upon judgment or reasoning in any respect whatsoever. "I see," "I sense," "I perceive," "I feel," "I observe,"—each of these expressions does describe a basis for my appreciation, or measurement, of myself as an indivisible whole person originating all of my human being.

As an individual I search myself. What does my human being consist of? The next view I see is a clarifying one. An individual can consist only of individuality. A self can consist only of selfness, quite as a tree can consist only of tree-ness. Everywhere I view myself, I find my property of individuality. As I grow my perception of my fellowman, my fellowman is seen as an individual, absolutely autonomous, radically unique. Thus, everywhere I turn I can find only particular selfness, such selfness characterized by the property of oneness. Seeing myself clearly as an individual necessitates my seeing every individuation of myself as living this property of wholeness which is true of my complete individuality.

Again, it is helpful to realize that all apparent "between-ness" can only really be "within-ness." Loving my everyone and my everything is only living to the full, my natural self-love. My living can be health education to the extent that I am capable of observing it as my own, hence expressing my spirited, soulful, humane meaning. I cannot remind myself too often of my selfish interest in every "view of life," for it is my living. Being extreme in this direction leads only to being extremely sane. Sensing intensely the absolute uniqueness of my unity or selfhood provides me with true appreciation of every element of my world which lives within me.

Sometimes one finds expressed the idea, "Medicine has two categories of health activity, (1) purely psychological, having to do with theory, and (2) purely 'physical' (nonpsychological), having to do with practice." The former medical living is then implied to contain all of the humanics, the latter all of the mechanics, of medical living. It is well to see any such illusion as this for what it is, namely an illusion, so that it can be dispelled, renounced as a dim view which does not recognize every aspect of the so-called "mechanics" of medicine for its true psychological significance. For instance, as a surgeon performing an operation, I am only applying my psychological insights in the form of skilled techniques.[4]

All of my human experience may be accurately defined as psychological only, insofar as it has any meaning for me at all. "Meaning" is always a mental element, a psychological entity. For instance the meaning of any word I use points to a living existent of my mind. As Bentham noted, "Lamentable have been the confusion and darkness produced by taking the names of fictitious for the names of real entities." The history of my language reveals *my* mental development. What has no meaning for me is incomprehensible to me. My life produces all that I make conscious, my consciousness does not produce my life.

The one kind of training or discipline possible is self-development. The best and most searching self-activity is called "learning." It is associated with the insight that meaning of any kind can be nothing but each one's self-felt experience. It is possible for me to live most of my life in the shallows of illusional "not-self,"

*Physician to the Bloomingdale Asylum for the Insane, New York City. *American Journal of Insanity*, January, 1845, Article I. The Poetry of Insanity.

without making the all important philological discovery that every word of every lagnuage of any meaning to me is a word which spells out something about me. I have no civilization or education whatsoever except that which is constituted of my own life. And my concentration upon this point of view, that my whole world is nothing but my personal being, is indispensable for my maintaining my sanity.

What is "on my mind" is a part of my mind, and cannot exist for me apart from my mind. My truth is found in my life process, there being nowhere else for me. In this same sense, all of my medicine must be observable as psychological medicine. This realistic view of objective truth (of seeing my identity in all of my living) spares me such a sorry scene as, "The psychiatrist is off his medical base, and every other doctor of medicine is off his psychological base." In 1905, Freud described psychotherapy as the treatment of every kind of health disorder with psychological means.[5] He described how the perceptual thinking of the scientifically schooled physician of his day specifically trained him in the use of sensations and perceptions, trained him as a means not as an end. This training, however, did not include the development of the medical student's appreciation of his sensations and perceptions as being creations of his own mind, as being his own psychological (self) data. To a varying extent the same kind of "impersonal" medical training exists to this day. However, modern medicine is already on the road to the discipline of self study with self-insight. The one mental identity underlying all body, and all other "external world," meanings, is becoming more and more the focus of attention of the student who is increasing his appreciation of his body as a mental instrument, and his "external world" as an internal existence of his own. As my Osler's beloved Ralph Waldo Emerson observed, the world is nothing, the man's world is all! Ricardo noted somewhat the same view, "The pursuit of individual advantage is admirably connected with the universal good of the whole."

For me to recognize every statement on psychological medicine as a clearly evident self-observation, it is essential that such deep medical insight be readily developed by me. Quite as the religious educator has discovered that everyone must save his own soul, as a physician, I may discover that everyone is entirely responsible for the preservation of his own health. The individual seeking religious or medical helpfulness finds it in the purest form in his religious or medical counselor who upholds this supreme degree of reverence for his own individuality. It is as though the radical religious, or medical, individualist is endowed with charismatic virtue.

The Comprehensive Medical View of Human Individuality

"We must all be born again atom by atom from hour to hour, or perish all at once beyond repair."
CHIEF JUSTICE HOLMES

In everything having to do with health it is essential that the over-all significance of self-esteem be thoroughly appreciated. The full realization of the health significance of self-esteem makes understandable the need for the most radical respect for the dignity of the individual, and accounts for the healing force concentrated in the physician's keen awareness of the inviolability of his own, hence his patient's, individuality. This extreme degree of self-consciousness, extreme sanity, is of greatest medical significance. It is implicit in every physician's most complete satisfaction in having his patient consciously help himself, admittedly cure himself. Only the human individual can strengthen or heal himself. Every kind of illness or accident threatens his proper wholesome feeling of self-esteem. His ability to restore himself is a power which he needs to see as his own in order that his full sense of self-esteem, healthy-mindedness, may be retained.

Being a medical educator, in my profession I require a psychology which will work peacefully for me, as I "see to it" that each one of my medical students reveres the dignity of his own developing medical character. I have attempted to record the psychological foundation of my pedagogical system as being nothing but the living of myself, and thereby growing my medical student instructor and curricular data, consciously as self-experiences of my very own. All of this, my medical Video, I write as an authority, but only with regard to my own genesis as a physician. Soren Kierkegaard, a self-conscious existent of one hundred years ago, recorded that his own individuality "by relating itself to its own self and by willing to be itself is grounded transparently in the Power which constituted it," adding "this is the definition of faith."

Any current doctrines of "medical education" which try to personify abstraction apparently by distraction from person, or make way for the studies by obliterating the student, are necessarily negative to the requirements and rights of human individuality. I am entirely a self, not an aggregate of self and not-self! Little wonder that the natural feeling of certainty has to be "scientifically" validated only by multiple verifications. Every aggregate is an individual one, but has individuality, or self identity, in no other sense than as an aggregate! Physiology not studied as psychological physiology must be studied as an aggregate of life processes. Instead of being viewed as naturally due to one organic wholeness, any fitness of its parts must be appraised as pure coincidence. The ontology of an aggregate is a matter of peripheral collection of each of its separate parts, not a growth of one being from within out. Every "part" of a human being has its entire life and selfish meaning by virtue of its being a part of a whole human being, and not an independent isolable unit of an aggregate. Each man speaks selfishly for all of himself, even though he must show the extent of his self-unconsciousness in the act. Every organ of his body utters the degree of self-consciousness with which he lives himself (*Organsprache*). Continuing research in psychological physiology, human physiology, made possible by insights derivable from self-consciousness, may confidently be expected to discover the truths of human physiology and of the proper care of the independent self-acting human individual.*

How I have grown higher and higher stages of mind and yet cherished for its indispensability to my healthy living each preceding deeper mental stage, needs no further elucidation than that I helped all of myself in that way. I continue my aim to live myself consciously for I find it too unhealthy to be continually aiming at self-ignoration. When I overwhelm myself with the importance of this or that, I can restore my homeostasis (mental equilibrium) by realizing that all of the importance of my "this" or "that" is only my own importance which is showing. How right the view, "I'm alive and that's what counts!"

The substantiality of my appreciating myself as a self-conscious one increases every time I live (create) the view of being my own "this" or "that" or "everything." The force of mind made up of my apperceptions pertaining to my consciousness of the allness of my individuality is most life-affirming. Realizing that I must grow myself in the direction of my devotion, I am devoting as much of my living as possible towards the creation of the self-conscious habit of mind, by repeated acts of seeing and owning my own soul in my swiftly growing sensations and perceptions.

My "old" psychology consisted of my traditional view of being an all-important mite in a mighty universe. I felt important even with that discouraging self estimate, but I did have no end of trouble "justifying" the sense of importance I had. With the extension of my consciousness to include more of my individuality, the very "external world" views with which I formerly had to dwarf my "self-realization" served to reveal my true self size. At last, the high sounding magnanimities of the consciously great ones began to make sense. Where else could the kingdom of God be but within me? How truly could I be true to "anyone else" except by being true to myself? How else can I love my neighbor except as myself? Why not love my enemies, my very own creations?—and so on. Gradually, I began to see clearly that formerly I used my imagination wildly to deceive myself that my external world was not mine at all, not my self-contained internality at all. As I revised my self-estimate to correspond with my growth of insight, of self-consciousness, I was appalled with the degree my verbalization of myself alone appeared to stand for a disease of language, a delirium of being able to live "out of my mind," "beside myself," "off my base" of selfhood, and the like. The significance of naming his things and his others for the little child, suddenly clarified itself as being of greatest significance for his sanity. How essential that every name be a synonym for his own name, and be appreciated as such!

As I calmed down, I realized that I had to go "through the mill" in order to get through it, and that everyone of my fellow creatures similarily must help, and is helping, himself, all that he can, to progress. "Meddling" grew to be a term of

*Dr. Thomas J. Heldt, for decades as the able director of the division of neuropsychiatry of The Henry Ford Hospital, created a splendid record of unifying psychiatric with general hospital living. Every general hospital has a wonderful development as it adds a psychiatric service. All honor to Dr. Heldt! Dr. Albert M. Barrett was the first in the United States to have a psychiatric service in association with a University hospital.

great meaning for me, designating my getting in my own way, defeating my purpose with good intentions unsupported by good insight. A particularly apt story, narrated by my Moncure D. Conway, helped me to stay out of trouble.

> An American missionary on a savage island made one convert but refused to baptize him, for he had four wives. But one day the convert came and said he had but one wife. "What has become of the others?" asked the missionary. "I ate them," said the convert.

In his spirited challenging book, "The Force of Mind," published by Funk and Wagnalls Company, 1902, Alfred T. Schofield, M.D., M.R.C.S., drew a curious analogy upon the prevailing neglect of psychotherapy in the treatment of the mind and the rigid British military tactician's refusal to adapt his warfare to the methods and terrain of his Boer enemy, counselling that the unsuccessful physician study the methods of the successful "quack." Perhaps the analogy is not curious, after all, if one considers the degree to which fitness of health has carried the significance of fitness for warfare. Today's physician is too often pictured as a man of war fighting disease, rather than as a man of peace kindly studying his human nature in order to become able to enjoy to the full his harmonious existence. Neither peace, nor war, nor anything else, can exist in "between-ness," for instance, between one man and another. Peace, or war, is to be found only within each human being. Between-ness is no man's land; within-ness is the nature of all that exists. In growing out of his quackery, did my historic physician try to throw the baby, "Imagination," out with the bathwater of "exact perceptions"? Does it not seem sometimes as if reference to "psychic" is not considered to be sufficiently "physic" even though it is the psychic alone which obtains? When I say "practical" I often mean "easy." In reading a text book of medicine today, I am profoundly moved by its impersonal tone, by having to read humaneness into it. That which is overlooked in study is apt to be ignored in practice, and so it is too often, is it not? Is it not easy to attend raptly even to his medical history and be inattentive to my fellow man? Can human being ever be taken for granted in careful medical work?*

The only force which can vitalize the "scientific data of medicine" is one which vivifies what meaning each of these facts may thus have. "Meaning" is entirely and clearly a mental force. If one can imagine even dead impersonal data as being vital with meaning, how much more quick with meaning may live personal data be imagined to be. Scientific flashes of imagination are, in every instance, deeply personal experiences having to do with consciously unifying meaning which was not consciously unified before. The human being is not a chaos of aggregated facts; gradually waking up to that fact has been a process of training myself as a medical psychologist. Everyone of my organs derives any and all of its meaning, its vitality, from one source only, from the truth that it is a part of the whole of my living self. To make something out of it otherwise is impossible. It reveals the meaning of me only in the sense that it is a part of me, and in no other way. This fact is useful in helping me to renounce the mad search for research upon my mind through the study of "something other than my mind."

Psychiatric undergraduate training for my Wayne medical student is presented as a means for his disciplining himself in the medical way of life, as a vital experience rather than as an intellectual lesson to be memorized. This training aims at every student's preparing himself to see that he necessarily applies psychological medicine in his medical practice of every kind.

The pressure and the rapidity with which each student must develop his medical character is analogous to the requirements of the force and accelerated mental growth which everyone undergoes during adolescent years. Thus, the four years of his undergraduate medical school living may be seen helpfully as his enforcing within himself a professional adolescence. The student builds the foundation of his medical character within this specified period of time, and needs the kindest care of himself during this formative period.

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*Training myself in exact observation is a total impossibility except insofar as I am able to be aware that all of my observation is self-observation, quite as all of my consciousness is self-consciousness. I cannot keep my mind out of its own activity. And as far as interpreting my mind by "non-mental" means is concerned, the statement of my Herbert Spencer about that is well worded, "There is not the remotest possibility of so interpreting it." Anything which I construct with the use of my hands can hardly suffice to account for the existence of my hands. A body without a mind obviously cannot *account* for mind; a mental body accounting for mind is nothing but mind accounting itself.

Extended and enlightened self-care cultivates best American citizenship. It holds the greatest diagnostic and therapeutic promise for the undergraduate medic, and it is most essential that this promise be brought to performance. It is vain for any student to usurp the name "physician" without devotion to his own health. By increasing his own power only can the student increase his ability to live his patient well. Conversely, anyone, even a physician, who is careless of his own health cannot be convincing as a source of health concern for his patient. This empowering kind of self-sight is a personal health requirement for the hard-working physician who may be killing himself by trying to cure "somebody else."

Deliberately and systematically striving for progress in the development of his own personal strength and health during his own preparation of himself to become a physician provides every undergraduate with the possibility of identifying himself as having a developing mind, as being and having a human life, which needs kind care. During his medical school years every student, the creator and creature of his own power, can benefit himself most from providing himself with the most considerate attention to his own nature and needs. His arousing himself from any lethargy into which he has fallen due to the mental habit of self-ignoration, his seeing what goes into the "making of the doctor," will enable him to discover what must go into the "making of the well man."

Hardness of medical character is possible only where there is repudiation of the truth that one's "otherness" living is one's very own. Such hardness does not proceed from carelessness of inflicting pain but from a want of self-consciousness, by means of which awareness of pain is conferred. It is a great awakening for the medical student when he suddenly sees the innumerable ways in which he can hurt himself without being aware of it; and the innumerable ways in which his organism betrays these self-hurts in organ breakdowns, visceral failures (skin trouble, kidney trouble, heart failure, and other disorders).

The contribution which medical psychology can make toward the more adequate understanding of health, its preservation, and the means of preventing its arrest, reflects the development of human insight, of human self-consciousness, within the past sixty years. Thus I see and report the sanity-preserving role of self-consciousness in all self-care and self-development. The integration of the principle of inviolable integrity of every human being and the matrix of the medical curriculum, seems to me to provide excellent opportunity for the growth of "comprehensive medicine." This health-producing integration involves the utilization of what properly revered human individuality has discovered about the emotional, and innumerably repressed, aspects of human complaints. The desirable goal of furthering the physician's comprehensive self-sight can be attained as it achieves more extensive living by every member of the medical discipline. The progress of this kind of development will depend largely upon the readiness of each member of my psychiatric faculty to live what he sincerely claims to be most life affirmingly.

Discoveries highlighting the healing force derived from appreciating the dignity of the whole individual man make it possible to offer scientific principles, as a helpful continuation of intuition, in heeding the health requirement of full-measured evaluation of the meaning of entire individual human being. Every bit of this advancement is in the direction of the goal of "comprehensive medicine."*

Mental Health and Conscious Self Government

> "In order that man may be persuaded to put forth the intense effort required to change chaos into order, he *must* feel that he has the necessary stature for the asignment, at least the potentialities. . . . It may appear absurd to philosophers, but in our age of specialization it is not only man's concept of matter which must come from science, but also man's concept of himself. . . . At the stage of specialization of our knowledge, to determine what is specifically human in man requires a veritable cracking of the concept of man. This cracking, in its turn, requires a concentrated effort of specialists; as much as was required for the atomic bomb. . . . If the concept is cracked, the release of spiritual energy will be voluminous enough to make physical nuclear energy behave. It might be powerful enough to light the lamps of peace and keep them burning."
>
> ANA MARIA O'NEILL

The method of enlightened medical progress, as does that of true democratic progress, lies I submit, in each citizen's conscious development of his wonderful ability to see his world as his own, and care for his world as himself. To the extent

*Dr. Raymond W. Waggoner, professor and chairman of the department of psychiatry at the University of Michigan, is outstanding for the excellent way in which he identifies psychiatry with medicine.

that a citizen neglects his world, he neglects his health. Self-government, conscious self-culture, is the mind healing and strengthening way of life. As Jefferson noted, "The laws and institutions must go hand in hand with the progress of the human mind." The Declaration of Independence itself is a sublime expression of healthy psychology, a treatise upon the nature and needs of the human mind. Wherever the dignity of individual man is consciously lived, liberty, equality, health, and morality find expression as the joy of being human. The Wayne medical student grows this kind of insight as an integral part of his study of psychological medicine. He discovers for himself the connection between his health potentiality and his wonderful government, the harmony of conscious self-care (self-government) and the physiological requirements of human life. As a precious by-product he sees for himself the health-defeating implications in "state" medicine, quite as he has always been able to see the analogous kind of contradiction implicit in "state" religion.

Conscious self-government has already been introduced into mental hospital living as a successful means of instituting therapeutic, instead of just custodial, patient care.[6] A conscious effort is sustained by each member of the department of psychiatry to uphold this health significance of conscious self-government. Dr. Elmer Hess, immediate past president of the American Medical Association, and honored as "the medical world's mouthpiece," made a discovery early in his practice: "The essence of self-interest is to behave in an unselfish manner." The wholesomely self-conscious physician does not practice his license without his self, any more than he practices his medicine without his license.

A precious wonder of my wonderful existence is the truly heroic life of every doctor of medicine, leading the hazardous career of a servant of the poor in health, a courageous explorer of the actual life of meaning, and an indefatigable researcher upon the most essential meaning of life, Health.

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CLINICAL MANIFESTATIONS OF ANXIETY

(Continued from Page 1254)

or is completely denied. Acting out of envy or jealousy, intolerance or suspiciousness may be seen. Or he may outgrow such manifestations and simply be the most disagreeable person in the room. Or, as with Joseph and his brethren, attempt to commit murder.

The various mechanisms which I have touched on: reaction formation, displacement, denial, projection, repression, conversion, are the most important ones involved in the psychic development. They can be found in the normal, the neurotic, the psychotic. They are reactions to anxiety. Through this, I have attempted to show a psychologic theory of mental health and mental illness which conceives of these entities as being the outcome of anxiety-motivated reactions to psychologic threats presented by the person's own impulses, which his early experience led him to treat as dangers.

Pure anxiety, mild or great, normal or pathologic, remains a frequent occurrence throughout life. Until it gives way to the more expanded emotions or until the stimulus for it is removed, it is one of the most painful and intolerable forms of displeasure. Most anxiety reactions are normal everyday occurrences and are relieved spontaneously and individually; a smaller number call for assistance by friends, physicians, clergy, or others who help people in such situations.

Anxiety is the most frequent single symptom in all medicine. The anxiety signal becomes the most powerful motivation force in human life, the power which organizes the character, the defenses, the neuroses. It behooves physicians to be alert to the presence of this symptom and to become familiar with methods not only of alleviating the symptom but also of understanding and removing the causes of the symptom.

A New Approach to the Clinical Management and Treatment of Behavior Problems

Progress Report

By John T. Ferguson, M.D.
Traverse City, Michigan

FOUR YEARS ago, fifty-seven patients from the women's halls and cottages left our hospital. Last year the number was 199. The facts behind these figures—the facts behind this 350 per cent improvement in chronic patient release is the story of progress in the management and treatment of abnormal behavior.

I want to tell that story. I want to tell where we stand in the fight to eradicate mental illness—of the progress being made in treatment of abnormal behavior—and the part you can play in this effort.

In research every phase of behavior is being studied—every phase from the behavior of a single cell to the behavior of whole communities. Every facet of psychopharmacology and physiology is being studied and re-evaluated. The search for new enzyme systems, new toxins and new chemicals within the body has increased. Today research is an all-out effort, and from all of this work something of value will undoubtedly appear. However, to date, the most useful and the most practical information has come from the clinical observations by private practitioners and state hospital clinicians—from men interested in their patients as people.

In most cases this honest, straight-forward type of clinical research has met with much opposition from the pure scientists and those individuals that believe you can measure and weigh a man's soul as you would a chemical. It has met this opposition and it will defeat it. This is true because in most cases we know neither the process by which these new drugs exert their peculiar effect upon human behavior nor the biochemical abnormalities associated with the behaviors we are treating. Consequently, this makes the purely scientific evaluation of these new drugs, on a strict comparison of percentages of diagnoses helped, almost analgous to what might have happened had the antibiotics been evaluated similarly in a group of febrile diseases many years before the development of the science of bacteriology.

Two months ago in Washington I participated in a government-sponsored "Working Conference on the Status and Improvement of Clinical Drug Evaluation Reports." It was not a publicized meeting, but a small conference of thirty-five Canadian and American doctors actively engaged in clinical research with the new drugs. At that meeting the committee members agreed that the new neuropharmacologic drugs are not specific for any particular type of mental illness, but are primarily for the management of abnormal behavior. This group also agreed that the dose should be tailored to the patient and that the best results were obtained when the patient was given rehabilitative help. In short, for the first time, this group agreed that the Art of Medicine was not lost—but was a vital part of a successful therapeutic program.

Consequently, I'm glad I participated in that meeting because it reaffirmed within me my belief that the answer to mental illness lies with the doctors in the front line. Doctors just like you and me—doctors that see their patients as sick humans, and not diseases.

I believe this because the fate of the mental patient is usually in the hands of the first physician who sees the patient. The ability of this doctor to control or ameliorate the abnormal behavior that brings the patient to his attention is often the difference between the patient's ability to remain at home and the need for commitment.

A few months ago I received a letter from a doctor in Charlevoix, in which he described a confused and disoriented eighty-two-year-old woman who was nude, incontinent and a terrific management problem for her relatives. He sent the letter because neither he nor the relatives wanted

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Presented at the Michigan Clinical Institute, Detroit, Michigan, March, 1957.
From Traverse City State Hospital.

to commit her if it could be prevented, and he wondered if we could help. I sent him a supply of drugs and a copy of our paper that appeared in the September, 1956, JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY. Three weeks later I received another letter from him thanking me for my help and describing the improvement the woman had made—above all, she did not need to be committed.

This story is but one of several that we have on file—and I take my hat off to all of these pioneering doctors, because they indicate that you—the doctors in the front line—hold the keys that will unlock the mysteries surrounding mental illness. You hold the answers for decreasing our state hospital population and the sociomedical problems associated with hospitalization. It is my belief that by the early detection and treatment of the abnormal behavior that first brings the patient to your attention, you can prevent many possible commitments from materializing.

This may seem like a tremendous challenge, but it isn't, because the management of a diabetic patient or a cardiac patient requires much more time and effort than does the management of a case of abnormal behavior. However, in each case the principle is the same, because with all three you are seeking to establish a balance compatible with the individual and his environment.

The better understanding of this balance technique in treating abnormal behavior is a good example of progress through failure, because this new approach was formulated as the result of adverse findings with many of the new drugs. Many of us lost sight of the basic balances of the body and treated only one component of behavior. With the tranquilizers we saw depression when we removed overactivity—with the analeptics we saw overactivity when we removed the depression. However, we also observed that in most patients, regardless of the outward behavior manifestation, there was an element of the opposite behavior present and that the proper combination of a drug for overactivity and a drug for underactivity would produce better results than either drug when used separately. I cannot give you the number of different combinations we have tried in our research, but I can tell you from this work that all types of abnormal behavior can be changed or controlled.

I have refrained from saying that the new drugs cure abnormal behavior because they don't cure —they merely make the patient more accessible for other therapeutic measures that, previous to administration of the new drugs, would have been useless. That is one point that is not fully understood. The drugs open the treatment door for the patient—how far he comes back into the world of reality depends upon how much help and encouragement he can be given.

Another point that is not fully understood is the need for individualization of dosage. This is true whether you are using small doses or large —and unless it is done you will run into side reactions and difficulty. To continue unaltered the same dose of a tranquilizer or an analeptic that produces clinical change in a patient's behavior will only lead to trouble.

In this respect, there is a marked similarity between the management of diabetes and the management of abnormal behavior. Were you to continue without change the original dose of insulin needed to reduce a diabetic patient's blood sugar, you would encounter difficulties. Consequently, you watch the blood sugar level, and, as it changes, you prescribe that amount of insulin needed to produce the blood sugar level and clinical picture that is optimal for each patient. The same is true in treating abnormal behavior, although no special diagnostic or laboratory techniques are needed. As the clinical picture changes, you must change the dosage as needed until a balance state is reached.

To do this, which drugs should be used? The logical place to find the answers is the literature. However, loaded as it is with ambiguous and contradicting statements, this makes a true study of each drug impossible. During the past two years, we have investigated thirty-nine of the new drugs. Many of these are highly active and are useful in special cases. For a chemotherapeutic program that you can use successfully, I find that our recommendations of last year are very adequate and should be repeated. Concentrate on one analeptic and one tranquilizer. Study them, know them, use them and understand them clinically—separately and combined. Let me show you what I mean—

Figure 1 represents behavior problems as they walk through your office door. From the shading, one sees that some are outwardly very overactive, others are quite underactive. Most are near normal.

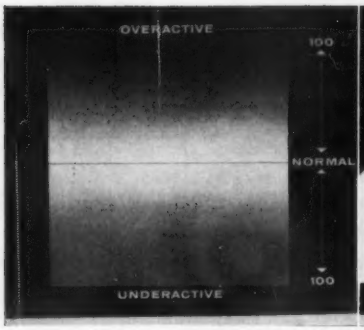

Fig. 1.

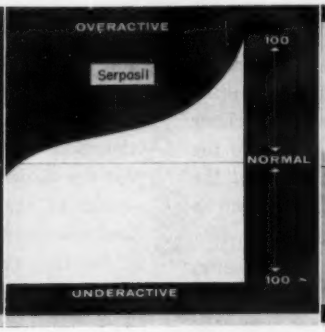

Fig. 2.

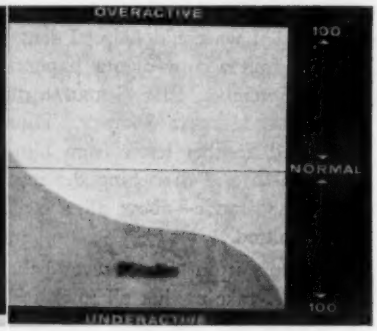

Fig. 3.

If only a tranquilizing drug is used, results will be similar to the dark area shown in Figure 2. The most overactive will be helped most. The less the overactivity, the less they will be helped. For a tranquilizing drug, I use Serpasil, because I consider it the least toxic and the safest to use for increased motor activity and aggressiveness. It has proven best for me with all overactivity, both mental and physical.

If treatment is confined to an analeptic, results will be similar to the shaded area shown in Figure 3. The more underactivity present, the better are the chances for helping the patient.

For an analeptic drug, I use Ritalin, because within therapeutic limits I have found it to be without side effects. It has proven safest and best for me with underactivity, both mental and physical.

Let's go a step further and consider treatment for both overactive and underactive behavior patients. The overactive patients are treated with Serpasil and the underactive patients are treated with Ritalin. From the clear area in Figure 4, it can be seen that there is still a big segment of behavior that is not being touched. If you look at this another way, it is then that you see more clearly how this untouched behavior segment has both overactive and underactive components, each of varying intensity.

It is definitely mixed (Fig. 5). How do you attack it? (Fig. 6). First, you can set up your results as percentages to see how many behavior problems will be responding to Serpasil and how many will be responding to Ritalin, after at least a year. This is quite important because, in any practice, the lasting benefits of the future are far more important than are the spectacular cures of today. Roughly, 10 to 15 per cent of all overactive patients on Serpasil alone will be doing fine after a year. About 5 to 10 per cent of all underactive behavior patients will be all right on Ritalin alone after a year. We see, then, that at the end of the year, 75 per cent of the behavior problems have not been touched—or will be showing changes from their first improvements.

The reason for this is not an accumulation of the medicines within the patient. It is an actual change within the patient. Where this change takes place with Serpasil and Ritalin, I do not know, but I do know that as the behavior of an individual moves toward normal, there is need for less and less medicine. Most of you know what I mean because you have used Serpasil for some of your hypertensive patients—patients whose hypertension was perhaps the clinical manifestation of increased anxiety or tension. Within a week or two, the blood pressure was down several points on maybe a dose of 0.1 to 0.3 mg. of Serpasil three times daily. The patient felt like a new man. Life was more bearable for him. For the first time in years, he was living. You've heard it—and felt good—until months later when the same patient came in depressed or complaining of always being sleepy. I have seen it happen on 0.1 mg. of Serpasil daily. I have also seen this same patient add 10 mg. of Ritalin twice daily to his daily 0.1 mg. of Serpasil and improve to a better mental and physical level than at any time in the past ten years. Therefore, to treat behavior problems properly, each must be treated individually as a mixture of overactive and underactive components.

To illustrate what we mean, in Figure 7 we have not only placed the two behavior components side by side, but we have also shaded the areas to show how, as the underactives awaken toward

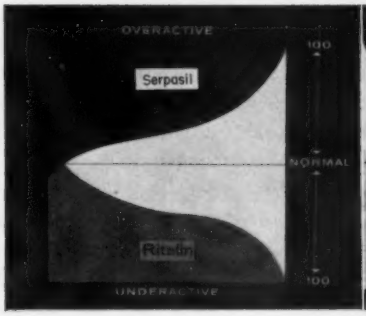

Fig. 4.

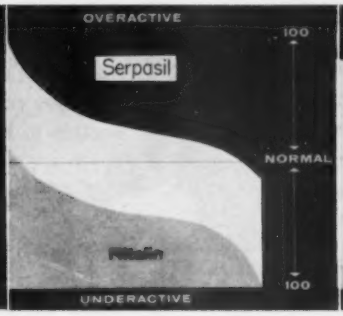

Fig. 5.

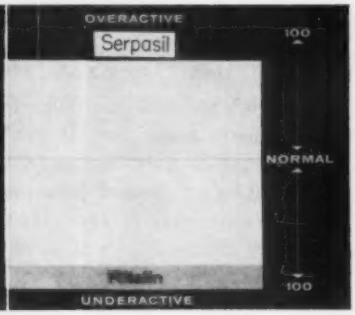

Fig. 6.

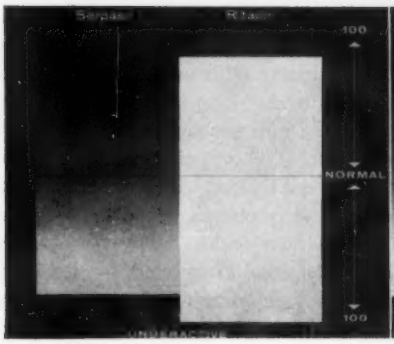

Fig. 7.

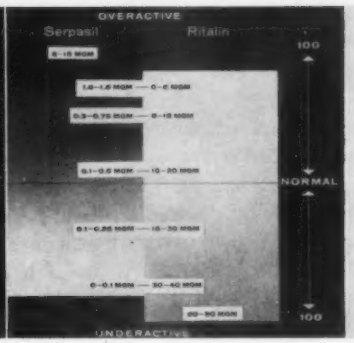

Fig. 8.

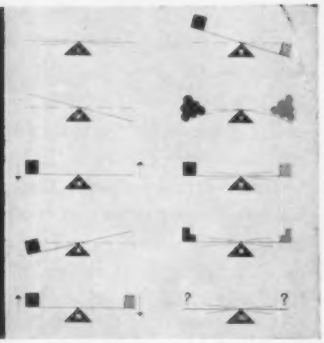

Fig. 9.

reality and the overactives "simmer down," each will not only need less and less of his original medicine, but to arrive at an active tranquility each will need to have the second drug added.

Figure 8 is the same as Figure 7, but with the dosages added. In each section we have used a dosage range rather than a mandatory figure. We did this to stress the individuality of each patient, as two patients with the same clinical behavior pattern quite often require different dosage levels.

Here approximately 15 per cent of the overactive group have no clinically recordable underactive component. This type of patient will require larger doses of Serpasil than any of the others. This dose range is usually 5 to 15 mg. of Serpasil per day, although it may have to be raised with a few overactive cases. Results with this overactive group will be faster and smoother if parenteral Serpasil is used.

A safe rule-of-thumb to follow for parenteral Serpasil is this—"If the patient can be given 7.5 grains of sodium amytal, then 5 mg. of Serpasil can be given. If not, then use 2.5 mg. of Serpasil." Either dose may be repeated every three to six hours, if needed. On the underactive side, there are approximately 10 per cent who will require 60 to 90 mg. of oral Ritalin a day. This works best when given 20 to 30 mg. three times daily. Using 10 to 30 mg. of injectable Ritalin solution intravenously with this underactive group will give striking results in most cases. They can then be maintained on the oral Ritalin.

It is from these two groups—the very overactive and the very underactive—that state hospitals secure most of their admissions. Proper treatment of this type of patient, therefore, should reduce materially the number of commitments each general practitioner will be forced to make in the future. It is a challenge to good medicine.

In the central group, very few patients will require as much as 1.5 mg. of Serpasil or as much as 40 mg. of Ritalin daily. In fact, the 0.1-0.5 mg. Serpasil and the 10 to 20 mg. Ritalin daily dosage will be used in office practice more than any other, as most patients will not be too far from normal behavior when first seen. Using divided doses will give smoother action. We like a three times daily schedule. The medicine may be

given before, after, or with the meals. It may be crushed and put in the food or beverage, if necessary.

Although we show the range for the combined use of both drugs, only a small part of your treatment will start that way. In most cases, there will be a dominant behavior. If it is underactivity, start with Ritalin. If it is overactivity, start with Serpasil. Then, as the dominant behavior starts to resolve, add small amounts of the second drug. We find that this early addition of small amounts of the second drug—5 mg. of Ritalin in two or three times daily to the patient on Serpasil, or 0.1 to 0.2 mg. of Serpasil added to the patient on Ritalin—produces better results and is easier on the patient and the doctor than to do nothing until side reactions or bad effects appear.

To understand better this balance-technique let us consider Figure 9. Behavior is like a teeter-totter. Normal behavior fluctuates, but maintains balance, even though one component may be dominant. It is when one factor, such as overactivity or underactivity, is clinically manifested that we have abnormal behavior. It is the inability of the individual to keep in balance—his inability to live with himself and others—that usually brings him to your attention.

If Serpasil is given in amounts sufficient to decrease the overactivity—would one expect that this overactivity should reach normal and stop? Of course not. It is like putting a rock on one end of the teeter-totter to bring it down—and expecting it to stop at center. Unless the dosage is adjusted in proportion to the patient's improvement, it is only right to expect the drug to continue acting on the overactive component until the negative remains clinically.

Now, if we add Ritalin to the point that this new underactivity decreases, we again cannot expect the behavior to reach normal and stop. It will again go on until the original overactivity manifests itself, even though the patient is on the original Serpasil dosage.

From this we see that we could continue adding to each side as they went up and down; we could add until we exceeded therapeutic limits. Don't do it the hard way; add the second drug when the patient starts to improve. It will take less drugs and less time.

After the patient is balanced for a month or two, decrease both drugs in proportion; that is, if he is on 1.0 mg. of Serpasil and 20 mg. of Ritalin three times daily, cut the dose to 0.75 mg. of Serpasil and 15 mg. of Ritalin three times daily. Do this every couple of weeks. In this way, it may be possible to eliminate both drugs. If not, you will arrive at the proper maintenance dose.

The cause of abnormal behavior is not always known. There will be times when a balanced patient will be temporarily upset or depressed. The addition of extra amounts of Serpasil or Ritalin for a short time will usually help the patient through these periods.

In this respect, another comparison with the control of diabetes is in order. If the diabetic overeats, he takes more insulin. If he fasts, he cuts his insulin. A similar adjustment in relation to the amount of mental strain, is needed in the treatment of behavior problems. However, the diabetic cannot make these adjustments unless the reason is explained to him. Therefore, for best results in behavior problems, it is necessary to explain to the patient or his relatives the action of each drug, the results expected from administration, and the symptoms which should be reported to you, so that you may adjust the dosage properly in order to reach the desired goal—active tranquility.

This implies a condition wherein the individual is mentally alert, yet calm and collected. It also means the absence of abnormal behavior and the inability of the individual to live with himself and others.

It is at this point of therapy that most patients have left the hospital and returned to society and their loved ones. Consequently, it is at this point that you—the patient's family doctor—can take over through some form of a parole system. We feel this way, because, in most cases, you know as much, or even more, about the patient's environment than we do, and you are more than capable of handling the medicines. Like the diabetic patient leaving the hospital, the mentally ill patient must have good medical follow-up. This is the weak link in our program today. We have been able to increase the number of chronic patients leaving the hospital by 350 per cent. We have also been able to increase the percentage of those that can remain out from 21 per cent to 68 per cent. However, our records show that 92 per cent of those that return to the hospital re-

(Continued on Page 1288)

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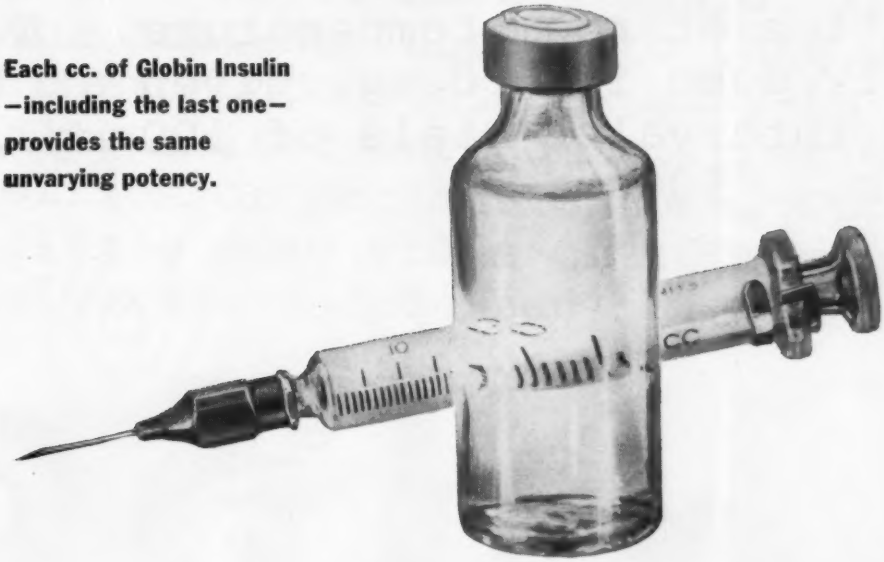

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Recent Observations

On Self-Regulated Schedules For Infants

Genetically acquired behavioral predispositions enable the normal baby to regulate its feeding intake and periodic hunger sensations, its feeding habits. These physiological regulatory forces may be satisfied by adapting the formula content and feeding period to the individual needs of the infant. It involves a sensible compromise between too rigid a schedule, geared to the clock and too lax a schedule, based on self-demand feedings. Such is the current objective: for either extreme can lead to infant feeding difficulties.

The newborn may become a feeding problem if the prescribed formula is excessive or the feeding schedule rigid. Every time he is awakened abruptly from satisfying slumber to be fed forcefully, the baby gradually loses his enthusiasm for the food and begins to resist the feeding. The young infant may balk at the crude introduction of a new food or feeding procedure without the proper prelude of gradual adaptation of taste, color, consistency and quantity.

The older infant weaned from bottle to cup may reject milk or go on a hunger strike. Devoted to his bottle he resents its sudden deprivation. It takes a certain readiness for weaning to make that change agreeable. Later the infant becomes somewhat independent of his mother and arbitrary with his food. What he enjoyed yesterday, he rejects today. If he distorts the diet for a day and his mother resorts to force, a feeding problem is in the making. Sensible decorum will solve these little difficulties before they become big behavior disturbances in childhood.

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Evaluation of the Use of Reserpine in the Psychoses

By A. L. Olsen, F.A.P.A., M.D., and
Harry Vander Kamp, M.S., M.D.
Battle Creek, Michigan

THE VETERANS Administration Hospital at Battle Creek, Michigan has 2,055 patients, all male, ranging in age from nineteen to eighty-six years. Ninety-seven per cent have psychotic diagnoses and eighty per cent of these are schizophrenic.

During the past two years Reserpine has been used at this hospital, and great changes have occurred. The time interval that has elapsed is now sufficient to warrant an evaluation of this medication. The use of the drug has been extensive enough to warrant a critical appraisal. During these two years a carefully controlled, subsidized research project evaluating the effectiveness of this drug has been completed. Further, a policy was initially instituted whereby each physician on the staff of the hospital had the privilege and responsibility of selecting patients from those on his service who were to receive the medication. An evaluation of the results obtained by these physicians has been made. All this has afforded a unique opportunity for a clinical evaluation of the use of Reserpine at this hospital.

Many changes that this medication has brought about seem truly amazing. Electroshock is now given only to those patients where it has a specific therapeutic effect, chiefly in cases of acute exhaustive psychoses, in depressions, and to catatonic patients who would require tube feeding. Hydrotherapy in the form of tubs and neutral packs is now used only occasionally, whereas two years ago it was used extensively. In order to accommodate the large number of patients it had to be available both day and night. Lobotomies have been discontinued. Many untidy patients are now continent. The aged and senile are less confused, better oriented, and memory impairment is less pronounced. Many patients who have been on the locked wards are participating in activities of their own selection, and have the privilege of being on open wards. The period of hospitalization for many patients, who likely would have been discharged ultimately without the medication, has been definitely shortened.

In spite of these great changes and the definite value of this medication in the treatment of these psychotic patients, it still cannot be considered as curative. The improvement most of the patients have made is still very marginal. While many patients show a change in emotional and feeling tone and an attenuation of hostility and anxiety, the psychiatrists have no difficulty in detecting the psychotic process which is basically unchanged. The more acceptable behavior is still very tenuous. Many patients are able to adjust very well in the hospital under a structured environment.

The majority of the chronic schizophrenic patients treated with Reserpine have failed to improve sufficiently to be eligible for early hospital discharge. Those who have left on trial visits or who have been placed in the family care program have needed much supportive therapy.

Some clinical complications from the medication, while not too frequent, can be serious and disabling. A few patients have developed depressive reactions. These have responded well to withdrawal of the medication. We have had several cases of acute vascular collapse. These, however, have responded well to symptomatic treatment. A more serious complication noted at this hospital has been the reactivation of peptic ulcer. Six patients have had severe gastrointestinal bleeding and three have had acute perforations. All of these required emergency surgical treatment. These cases are often difficult to detect because of the peculiar indifference to pain many of these schizophrenics show. Constant vigilance for detecting these complications has been necessary and rewarding. While it is gratifying to see the tranquilizing effect of Reserpine on patients with assaultive, destructive and combative behavior, also the disappearance of the choreiform

From the Veterans Administration Hospital, Battle Creek, Michigan.

movements in Huntington's disease, it is most discouraging to see another neurologic deficit appear in the form of Parkinsonism.

The physicians at this hospital realized very shortly after using Reserpine that it was very difficult to predict which patients would respond favorably prior to giving the medication; therefore, a carefully controlled study of 170 schizophrenic patients was done. Some received Reserpine and others a placebo.* The double blind technique was used. One group of these patients represented the borderline psychotics and those who were in good contact and on an open ward. Another group were the acutely disturbed, displaying periods of agitated violent, combative and uncontrollable behavior. Another group were those often described as "elopers." Some of these were in fairly good contact with reality; many were actively hallucinating and revealed delusional ideation. The fourth group represented the severely regressed patients. They had adjusted well to a structured hospital environment and appeared quite comfortable with their delusional ideation.

The results of this study show that the tranquilizing effect of Reserpine shortened the hospital stay of many of the borderline psychotic patients and those who were in good contact. In the majority of these cases the hospital stay was so short that an accurate evaluation of the change in psychopathology was not possible. In the acutely disturbed patient, the personality disorganization which had become progressively more severe was at least partially halted. There was a definite improvement in conceptual thinking. Hallucinations and delusional idea—were diminished and masked. These patients became better oriented for time, place and person. Their speech was more relevant and the effect more appropriate. The tranquilizing effect of Reserpine is, indeed, amazing in this group. The eloper became less seclusive, less resistive, less hostile and more cooperative. The chronic regressed patient who was well adjusted to his hospital environment showed the least improvement.

A global evaluation of these patients reveals that changes occur only in specific areas of psychopathology. The response to Reserpine also showed a peculiar selectivity. Some patients made a good response, others failed to make any improvement. Even after completion of the study no definite prognostic sign could be elicited which would indicate which of these patients in a comparable group would improve and which would not, prior to a therapeutic trial with Reserpine.

It does seem logical to infer that this peculiar selectivity and specificity represents a neurophysiologic difference in these schizophrenic patients. This in turn suggests a metabolic disorder, both cellular and humoral in origin. It lends further support to the concept that a biochemical factor is involved in schizophrenia. Some recent research on serotonin is suggestive of the nature of this biochemical factor.

Our experience indicates that some patients respond better to Reserpine, others to Chlorpromazine, others to a combination of these drugs. Some of our patients who have failed to improve on the drugs have subsequently made a very good improvement on insulin coma therapy. Some who have failed to improve on insulin therapy have done remarkably well on further treatment with the tranquilizing drugs. The physical medicine rehabilitation service, special services, individual and group psychotherapy have been more valuable in the treatment program than ever and should be utilized to the fullest extent. It is our opinion that the older forms of therapy should not be discarded. Each patient must still be individually evaluated. Certainly more research and clinical experience in the use of these newer drugs is needed.

*Sandril and the placebo were donated by the Eli Lilly Company.

The history is the backbone of clinical investigation.

* * *

Complete anacidity and a short history, unlike the achlorhydria with a long history, strongly points a suspicious finger towards carcinoma.

It should be regarded as axiomatic that the harder it is to recognize gastric carcinoma, the better the prognosis.

* * *

Addisonian pernicious anemia is often confused diagnostically with carcinoma of the digestive tract.

Management of Chronically Disturbed Patients with Sparine

By Horace J. Prescod, M.D.
Philadelphia, Pennsylvania
Merlin C. Townley, M.D.
Eloise, Michigan

SPARINE or Promazine hydrochloride is one of the phenothiazine compounds that has been significantly successful in the treatment of acutely disturbed patients,[1] especially in the treatment of acute alcoholism.[2] It has not been known to have severe side effects, a fact which has been attributed to the absence of the chlorine radical on the phenothiazine nucleus. Chemically, this is the only difference between chlorpromazine and promazine.

Therefore, we thought it useful to administer the drug to chronically disturbed patients with a twofold purpose in mind: (1) to see whether it would have a significant effect in calming chronically ill patients who had been previously treated with any of the chemical or physical modalities, and (2) to test it for undesirable side effects.

Fifty-nine disturbed patients from the chronic female wards were selected on the basis of having had previous physical or chemical treatment—alone, combined or successively. Thus, each patient was her own control. By the process of random selection, they were divided into two groups. Thirty-one were placed in the Sparine group and 28 in an EST group. This was to act as an additional control. The ages ranged from twenty-six to sixty-four years and the periods of hospitalization extended from one and one-half years to twenty-nine years. Eighty per cent had the diagnosis of schizophrenia. The remainder fell into the categories of chronic brain syndrome, involutional psychotic reaction and manic-depressive reaction.

Prior to treatment, blood pressures, pulse, and temperatures were taken and recorded. Complete blood counts were also performed. Finally the patients were evaluated by the ward personnel. A rating scale was used. It was divided into fourteen subjects, such as sleeping habits, eating habits, sociability, speech, et cetera, covering all conceivable aspects of ward adjustment. Each subject was subdivided in terms of degree of increasing abnormality and numbered. Thus the lower the number (and, hence, the total score), the better the adjustment and vice versa. The lowest score possible was fourteen. This represented a condition good enough for convalescent leave. The highest score possible was fifty; this represented the worse possible adjustment.

The protocol was set up as follows: Each of those on Sparine received 100.0 mg. of the drug intramuscularly daily for four days. Oral medication was started at the same time. Only 100.0 mg. tablets were used. For the first two days, each patient received one tablet at bedtime. This was increased to one tablet twice a day for two days, then one tablet four times a day. Four hundred milligrams a day was arbitrarily set up as the maintenance dose. The amount was to be increased or decreased as the individual required. The tests extended over a two-month period. Complete blood counts were done every two weeks.

Just before administering the intramuscular dose, the blood pressure and pulse were taken and recorded. They were taken again one hour after the injections. In the hypertensive patients, the pressure dropped as much as fifty points; in the normotensive patients the drop averaged ten to twenty points. Thereafter no particular pattern could be ascertained, but there was a gradual, continued decline over the period of a month in about 60 per cent. In the remainder, the blood pressure started to return to normal subsequent to the termination of the intramuscular injections.

There was only one significant side reaction at that time—a rash at the site of the injection. A few patients complained of weakness and drowsiness initially. There were no incidents of syncope. After the first few injections, there was no further evidence of weakness. During the period of injections, it was noticed that most of the patients were quieter and more co-operative, but with the shift to oral medication there was an upswing towards

From Wayne County General Hospital.
The Sparine was supplied by the Wyeth Laboratories.

the former agitated behavior. A few patients did not respond to the intramuscular injections, even after four days, and required additional injections extending up to a month.

At the end of two months the drug was discontinued, except in those patients who seemed to have benefited from it. Both groups were again evaluated by the ward personnel. Twenty-three, or almost three fourths, of the Sparine group showed some improvement. One-fourth was unimproved or worse. Almost identical percentages were obtained for the EST group. Twenty-one, or exactly three fourths of the EST group showed some improvement, as against seven or one fourth, who showed no improvement. However, there was one striking difference. In the EST group, one patient improved dramatically (14.5 point decrease). This was a forty-six-year-old woman with the diagnosis of schizophrenic reaction, chronic undifferentiated type, who is now on convalescent leave.

In terms of side effects, it was noticed that a small percentage of the patients developed a mild leukopenia (for our purposes a white cell count below 5,000). The white cell counts declined appreciably in 17 per cent, but only one fell as low as 2,550. No symptoms that could be associated with this decline were noticed. All the lowered blood counts returned to their former level within a month after discontinuance of the drug. One patient developed a serious macular rash, which, although treated with Benadryl, became worse. It was necessary to discontinue the drug on this one patient. No other significant side effects were noted. In particular, no patient developed seizures which Barsa and Kline[3] and Voegle and May[4] observed independently in their studies.

Summary and Conclusions

Fifty-nine chronically disturbed female patients who had previously failed to respond to either physical or chemical therapy, or both, were divided into two groups on the basis of random selection. Thirty-one were placed in the group to be given Sparine and twenty-eight were placed in the EST group. Thus each patient not only acted as his own control, but also the EST group acted as an additional control. Complete blood count, pulse, pressure and temperature were taken prior to the tests. In addition, each patient was evaluated by the ward personnel.

The treatment lasted for two months and consisted of intramuscular injections of 100.0 mg. daily for four days and oral doses of 100.0 mg. tablets starting from the first day and increasing to 400.0 mg. daily. This was the average dose.

Blood pressures fell significantly within one hour after the first intramuscular injection. There were no instances of syncope. A slight majority continued a gradual decline during the first month; the remainder returned to normal following cessation of the intramuscular injections. A transient weakness and drowsiness were observed in a few. A rash developed in one at the site of injection, but this faded in time.

At the end of the two-month period, the patients were again evaluated by the ward personnel. Almost three-fourths of the Sparine group showed some improvement; the remainder were unimproved or worse. Exactly three-fourths of the EST group showed some improvement. One of this latter group improved enough to be placed on convalescent leave.

In terms of toxicity, 17 per cent experienced a mild decline in the white cell count, but all returned to normal within a month after the drug was discontinued. There were no associated symptoms. In one case, a macular rash developed that was so severe that it was necessary to discontinue treatment. No other side effects, including seizures, were observed.

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Psychiatric Aspects of Gynecologic Care

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IT MAY NOT be inappropriate to start this discussion of psychiatric aspects in gynecologic practice with a reference to the importance of sex at the very beginning of human life here on earth, and I quote from Genesis Chapter I, verse 27—"So God created Man in His own image—male and female created he them." Man and woman, masculine or feminine, we were brought into the world, and the animals also came in two by two. The biblical writer paid no heed to other species that deviate from the bisexual pattern, such as certain species of snails and mollusca that mature in one hemaphroditic individual the dual potentiality of spermatogenesis and ripening ova. But in the higher species procreation remains bisexual today as it was in the distant past. It is no mere coincidence that our sex necessarily influences the attitudes and attributes, the conditions and conflicts that govern much of our thinking and activities.

Psychiatrists point to three stages in sexual maturation common to men and women. The primary phase extends from before birth to the first few years of infancy, and is characterized by a neuter, ano-oral type of sexual satisfaction. Then comes the second, homosexual phase, to be followed sometime in adolescence by the mature heterosexual era. Such development occurs equally in both sexes, and the basic contours of personality are often directed not only by the satisfactory graduation from the homosexual to the heterosexual stage, but also by the adequacy of the elemental maleness or femaleness of the individual. I have sometimes speculated on why those individuals that appear to excel in any creative art or craft—be it cooking, or weaving, or pottery, music or painting, sewing, or even creating a new coiffure—are almost always males. Pick whatever pursuit you may, through the ages men have dominated the techniques. To women alone, however, even to the lowliest street walker, is given the gift of creation—the sublime ability to produce a living, breathing bit of life itself. Why should there be any wonder that her life, then, in the third or mature stage of development should be wrapped about the central theme of reproduction, the potentiality for it or her demonstration or rejection of such a God-given power?

If this be true, then, much of the mental as well as physical ill health of the individual woman can be properly understood only in the light of her conscious or unconscious acceptance of her feminine role. The menstrual function symbolizes this role. Disorders of menstruation threaten the personality structure at its deepest level—that of femaleness—and an awareness of emotional factors in women's complaints is recognized by all in the field of gynecology. It is only surprising that in a similar way we don't have a special field of androcology—for the ill health involved in the frustrations implict in being a man can surely bring forth many conditions that our genitourinary associates, peering through their cystoscopes, may be all too myopic to observe. Perhaps this field of androcology offers a wide-open challenge to the ever-increasing numbers of girl graduates from medical schools in the future years.

Gynecology, then, means the science of women's diseases, and their adequate treatment calls for as complete as possible an understanding of the individual patient herself—her life-situation and her problems. One cannot concentrate only on the surgery of the pelvic organs and their pathology and leave out the pituitary, the thyroid and adrenal glands and the part they play in reproductive physiology. Nor can one overlook the psyche—the substrate that motivates and conditions all our actions and responses. To be a thorough gynecologist demands knowledge of the part played by these three essential disciplines—pelvic surgery, endocrinology and psychiatry. The purpose of this paper is to emphasize the outstanding importance of the psyche in all gynecologic complaints. One of the best ways to illustrate this is, perhaps with a few case reports.

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Case Reports

I would like to present three types of cases: first, one with organic disease whose diagnosis was obscured by the more obvious signs of a neurosis; then a patient with important psychiatric implications in her clearly organic pathology; and third, two cases with primarily emotional disturbances presenting symptoms that suggested a somatic disorder.

We are often too prone to react in an unreasoning way to our patients' personalities, especially when the past history and negative physical findings seem to support the hostility with which we may have labeled the patient a neurotic. Once we have even unconsciously committed an opinion of this sort it may be difficult for us to shake it.

Case 1.—M. P. was a thirty-seven-year-old mother of five who had a hysterectomy in (March) 1956 after a period of observation of over three years for intractable meno-metrorrhagia, having had five previous admissions including four curettings.

At her first admission in 1953, her hematocrit was 32, all the usual studies for blood dyscrasia were in normal range, and the dilatation and the curettage showed normal proliferative endometrium. The almost constant bleeding recurred shortly after, and for the next year hormonal control was attempted but failed. It was established by endometrial biopsy that ovulation generally occurred in relation to monthly increases or "hemorrhages" that punctuated the persistent flow. Progesterone was thus found, as anticipated, to be no help. Testosterone was tried both orally and by injection. A course of Blutene was given. During this time the patient's personality presented so many outstanding difficulties, and there was so little co-operation in the outlined medical programs, that she was seen by our psychiatrist and followed by the psychiatric social worker.

The social history of this well-groomed and physically attractive twice-married girl brought out that she, the fourth of seven children, had always been expected to do all the hard household work. Her menarche was at age fourteen and menstruation thereafter was uneventful. She married at seventeen and had her first child in a year. Her husband was killed in an accident a year later. She left the child with her mother and came for work to the city. A sister also came against her wishes and she had the police force the sister to leave town for promiscuous behavior. Later on, the same sister is blamed for a court action that separated her from her oldest child, who was then brought up by an aunt. She married again, a bartender, and had four children in the next eight years. Her home life has been one of violent quarrels with her neighbors as well as with her husband. He is said to accept only two of the four children as his own. Her personality was summarized by the psychiatrist as demanding, sarcastic, belligerent and infantile, with many hysterical traits, yet seductive and flirtatious. She showed hostility to all those she dealt with; at home she would lock herself in a closet or resort to face-slapping during violent arguments. She was afraid of further pregnancies and used the excuse of her bleeding to deny her husband, or else a compulsive and feverish obsession to clean the house, leaving her too tired for sexual activity. Likewise, the attempts to gain her co-operation in clinic programs were repeatedly upset by missed visits, either because she would say she was bleeding too hard to come in for the planned injections, or she was too tired, or had to clean house that day, and so forth. The psychiatrist's opinion was that the major causes for her anger and hostility were too complicated and she was too disturbed for psychotherapy to offer any help, but that the social worker could give her some supportive treatment.

For a period of six months her bleeding was relatively controlled, during which time she leaned heavily on a sympathetic resident and the social worker. When the resident left the hospital, however, the metrorrhagia returned. We felt that she represented a complicated emotional problem centered on fear of pregnancy and unresolved hostility to her feminine functions; yet, because she was ovulating, an admission was advised for another dilatation and curettage to rule out "irregular shedding" of the endometrium. At this admission, she showed normal secretory endometrium, but a medical consultant found her serum iron to be down to 20 gamma per cent (with a normal minimum of 80). Her hematocrit was 27, and we reversed our diagnosis of primary emotional causes in favor of the tentative hypothesis of prolonged serum iron deficiency and depletion as the major explanation of menorrhagia. She was given a total of 2,400 mgs. of iron intravenously, and with transfusions her hematocrit was brought to 37 after two weeks. For two months she had less severe menstrual flow, then, in spite of an acceptable serum iron level, her hemorrhage recurred. Again, we were forced to conclude that her psychiatric status was paramount; she was readmitted for treatment of her blood-loss anemia. After considerable discussion and further interviews with the psychiatrist, a hysterectomy was chosen as the best definitive treatment, although pelvic examination was still essentially negative. It was during this experience that her infantile behavior, her antisocial feelings and helplessness were brought out. She did quite well, and one month after the operation was doing a full schedule of home work, albeit with many arguments and rages.

Comment.—This, then, appeared at first to be the case record of an unhappy, maladjusted mother of five, poorly equipped to handle the burden of wifehood and motherhood, who seemed to have developed uterine bleeding as a solution to her fears of further pregnancy, in spite of a fairly normal endocrine status. Our confidence in the psychiatric etiology of this was shaken by the demonstration of a severe deficit in her serum iron,

but restored by the recurrence of bleeding after the deficit had been made up. In spite of the presumed emotional etiology, hysterectomy was advised eventually as the best solution to her problem. At operation, a different answer was found. She had diffuse adenomyosis which offered a reasonable organic explanation for her prolonged bleeding, a pathologic entity never considered because of the emphatic, repeated display of emotional insecurity and our too ready diagnosis of her as a hopeless neurotic.

The next case represents those whose organic disease is sufficiently confused by emotional factors to interfere with the optimal therapeutic program.

Case 2.—Mrs. A. A., was a forty-eight-old married woman with three daughters, who was first seen in 1952 in the clinic complaining of bladder weakness. In addition to cystocele, she was found to have large fibroids. Since there had been no hemorrhage, operation was advised, but considered elective, and she was urged to make an appointment within a few months. She did not return, however, until uterine bleeding of seven weeks' duration occurred a year later, when she fainted, became scared, and at her examination showed a hemoglobin of 10 gms. per cent. The cystocele had increased, and the fibroids were larger, and she promised to come in for hysterectomy in three weeks, but missed her appointment because, she said, the small store that she helped to manage was too busy at that time.

Three months later on her return, we learned that her twenty-nine-year-old daughter had just undergone a mastectomy for carcinoma and the fear of malignancy, rather than persistent hemorrhages, had driven Mrs. A. A. to come back. She was given an admission appointment for the following week but failed to keep this date. Four months later she again returned and a 6 cm. cystic structure was felt for the first time in the right vault, independent of the fibroids. Unreasonably, she then wanted an operation done the very next day. She did come in to the hospital in ten days and psychologic tests preoperatively demonstrated the conflict between her fears of the operation and her fears of cancer. Her only defense had been to turn and run away. Finally, through her daughter's crisis, she found she could master the worry about surgery by giving way to the more overpowering fear of malignancy. Through her operative convalescence, an almost symbiotic relationship between mother and daughter was observed, with our patient rather passively enjoying and taking part in the daughter's acting out with hostility her mother's suppressed fears of going crazy. Actually, the removal of a dermoid cyst and large fibroids was attended by a surgical uneventful recovery.

Comment: Little need be added to this rather classic case of a woman who suffered severe hemorrhages for four years from fibroids because she believed, first, that she would lose her mind following hysterectomy, and, second, that she had cancer anyway and operation would be futile. We were unaware of the daughter's controlling influence until it became clearly apparent that it was the younger woman who realistically faced mastectomy and lived through her operation, that convinced Mrs. A. A. to follow through with her own appointment for surgery.

Finally, the next two cases are from those whose outstanding disorders are psychologic, but presenting somatic symptoms that primarily brought them to the gynecologist.

Case 3.—Miss S. A. was a twenty-five-year-old single girl of Greek Orthodox extraction who entered the emergency ward at night complaining of right-sided abdominal pain of twelve hours' duration. She had a leukocyte count of 15,000, a fever of 101° F., and tenderness localized by her in the right lower quadrant and in the right vault on pelvic examination. An operation for acute appendicitis was performed that night. Exploratory laporotomy was entirely negative, however, except for noting an acute hyperemia of the Fallopian tubes. She was seen postoperatively by the psychiatrist in an effort to understand better the background in this case for the error in mistaking salpingitis for appendicitis.

This attractive dark-skinned girl quickly admitted to her short temper, irritableness and "nerves," which she blamed on a mother who continually badgered her to get married but scolded her for being out after ten o'clock. Her past history revealed chronic indigestion, and a normal menstrual cycle till the last flow, ten days before admission, which had been preceded by an unusual discharge, and continued longer than usual. She had been going out with a married man of a different racial origin and, although there was no hope of marriage, she had recently had sexual relations with him. Only very recently a girl friend of hers had become illegitimately pregnant, and had been ordered out of the house of her mother. The mothers of the two girls had discussed this action, and Miss A.'s own mother had said she would do the same if any of her three daughters disgraced her in this way. Thus it was that the patient became subconsciously fearful that the unusual flow preceding her admision, followed by a fever and abdominal pain, was probably a consequence of a pregnancy of her own. Unable to formulate this fear, yet desperately worried over the consequences, she apparently localized her abdominal pain to the appendix region. Postoperatively, cervical cultures were found positive for a Neisserian infection.

Comment: No valid criticism need be sustained for performing the negative exploration in such a case where the risk of perforated appendix seemed greater than the risk of the laparotomy. In retro-

spect, one may argue that the history of sexual activity followed by discharge, an unusual period, then fever and abdominal pain should have provided enough suspicion to await cervical cultures. When the strict orthodox upbringing and the coincidence of the girl friend's illegitimacy were brought out, one can readily understand the motives behind this girl's anxiety and the quick cooperation with the night resident's suggestive examination that pointed towards an acute appendix as a face-saving solution.

Case 4.—Miss M. E. was a twenty-two-year-old student nurse who came for relief of her monthly cramps which were so disabling that she was falling behind in her school work and was afraid she could not graduate with her class. For the first thirty months after menarche at age eleven, she experienced no menstrual pain, and her mother would ask her "any cramps yet?" When she was fourteen or fifteen, she began to have severe pain, nausea and vomiting that persisted with regularity to the time she was first seen. Codeine alone was found helpful. Other than a second degree retroversion, examination was essentially negative. She was given two injections of 10 mgs. of estradiol propionate early in her cycle, and for the first time in eight years experienced no menstrual discomfort whatsoever. Ovulation was then allowed to recur, and this was followed, as anticipated, by the usual disability "worse than ever before." Oral stilbestrol, 1 mg. for three weeks failed to produce any estrogen withdrawal flow. She was then started on the "stepped-dose" regime first suggested by Brown and Bradbury, receiving 2 mgs. of stilbestrol the first week of her cycle, then 4 mgs. for a week and finally 6 mgs. for a week. This regime was repeated for three months in a row with complete relief and psychologically acceptable uterine flows, and then the fourth month ovulation was allowed to occur. Neither papaverine, trasentine, valoctin or novatrin were at all helpful when she had her dysmenorrhea. For the final year of her training, however, for three out of every four months the "stepped" stilbestrol regime eliminated the pain and the absence from work, and she felt grateful that she was thus able to graduate on time.

Shortly after graduation she was treated in the hospital for acute peptic ulcer symptoms which yielded to medical measures. In the spring of the next year she married. After a year and a half of the concentrated stilbestrol treatment she was told that this must be terminated, and that the choices for her were either pregnancy or a pre-sacral resection. She felt too financially insecure to have a baby and did not want to stop working to have the operation. She compromised on the use of stilbestrol only every other month, and agreed to the condition imposed on this decision that she should start psychotherapy.

It was difficult for her, at first, to gain confidence in the therapist and accept the idea that she might have pertinent emotional conflicts. After a relationship was established, she described how she had to give in to her intense pain in order to get her mother first, and now her husband to take care of her as a helpless child. She claimed she wished she did not have to work and could afford a baby. Later on she expressed her resentment toward the mother for pushing her into growing up too fast and her dissatisfaction in the childishness of her husband, thus placing too much responsibility on her shoulders. She also felt that her dysmenorrhea had served as an outlet to insure her the kind of care she missed as a child. In these interviews, she began to realize that she was taking refuge in her husband's inefficiency as the excuse for her feeling that she was not yet sufficiently mature to be a mother. Nevertheless, she became aware of a deep desire for a child. Seven months after starting this therapy she voluntarily gave up all further estrogen treatment. Her cramps had decreased sufficiently so that they no longer kept her away from work. Her interest in accepting the responsibilities of pregnancy continued to increase and she was very pleased in five months to become pregnant. Delivery was uneventful; she was happy looking after the child and grateful for the therapist's help in reaching a decision to give up the hormone treatment and become pregnant. It is of interest that she still continued to have cramps after the baby arrived, yet these were not severe, and the following year she became pregnant again.

Comment: There is little doubt that the rather massive stilbestrol treatment did give this girl the chance to conclude her training that was threatened by her disabling cramps. The inevitable result of the painless anovulatory flows was to make her dependent, almost addicted to the estrogen. Further one may well wonder whether the activation of her ulcer leading to a hospital admission may not have been a somatic outlet in another form for her conflicts, once the monthly cramps had been taken away. She was, however, intelligent enough to make full use of the therapy interviews, and it was rewarding to note her progressive improvement, her voluntarily giving up estrogens, and her happiness in finally becoming a mother.

Discussion

These cases, of course, are not in the least unusual; every one with experience of the clinic or office practice of gynecology can reduplicate them or their like many times over. One cannot squarely meet this challenge by refusing to recognize its existence. The major problem for us lies in how to deal adequately with it. What steps can be taken to weigh in the balance the significance of emotional conflicts in gynecologic complaints?

First, and most important, there is no single

therapeutic approach that can offer as much success for all functional disorders as the deep concern, wise guidance and sympathetic understanding that the dedicated clinician can devote to the patient herself and her individual problem. This means a careful history that includes background data on family and siblings, the anxieties, ideals and hates of childhood and adolescence. This takes time. How few of us in a surgical specialty have the time and the interest to try to learn about our patients in this way! How little our training has prepared us to be able to bring some order out of the chaos of irrelevancies that may pour out during the first examination! The best we can do most of the time is to grasp those significant danger signals that put us on our guard to think twice before we schedule an elective operation, and to insist on further knowledge before deciding on an irreversible therapeutic course.

If we are fortunate to have the close collaboration of a psychiatrist, many a needless operation may be avoided entirely and other elective procedures can be planned with optimal chance of inflicting the least psychologic trauma. I am constantly impressed by the abundance of ordered facts obtained in an hour's interview by the skilled and experienced psychiatrist. As an added aid, I am deeply indebted to the knowledge provided by our consultant psychologist through the use of projective tests, the well-known Rorschach, the thematic apperception test, draw-a-person and Sentence-Completion tests. Finally, in surgical cases, we have been rewarded by studying the pattern of a patient's recovery from anesthesia as a prognostic sign of their future convalescence. Five minutes or less of the surgeon's time spent in the recovery room will give him a telescoped view, as it were, of the way his patient will be able to handle the postoperative period. Those that moan and groan, thrash about, demand more medication, resent and reject all proferred help while in the twilight zone before full conscious mastery returns—such patients are most surely going to be difficult to handle, aggressive, complaining, infantile and dependent. The others who seem to summon up some deeper strength from their previous life experiences to accept the discomfort with confidence that they are obtaining all possible help—these patients will get well in progressive, predictable manner.

In conclusion, I would like to make a few remarks about the importance, obligations and responsibilities of our specialty in relation to the health of our nation which, as the American Medical Association repeatedly reminds us, is the best in the world today. This is certainly borne out by statistics on infectious diseases, and various mortality rates. But there are few nationwide or worldwide statistics on the incidence of gynecologic conditions aside from malignancy. A more revealing index of the health of America's women is provided by a truly disturbing accounting of sexual unhappiness, broken homes, illegitimacy, septic abortions and sterility. It is impossible to obtain accurate figures, but estimates indicate, for instance, that 20 million Americans are battling with the frustrations of infertility; ten million others have been involved in divorce action. Each year there are over 100,000 children born out of wedlock, and the figure of 300,000 criminal abortions annually has been considered a conservative guess. The numbers of sexual deviates and delinquents are unknown. Surely such figures speak eloquently of a shocking degree of sexual immaturity and inadequacy, of maladjustment and irresponsibility of parents, a disturbing measure of mental ill health of the women of our nation.

I do not believe the medical profession can shrug off responsibility by claiming this state of affairs is the concern of parents, church, or schools. I think that our own specialty is particularly concerned. In the age before specialization, the family doctor was the guardian, teacher and friend of his intimate clientele. He knew the family background, the hopes and worries of young parents whose children he delivered and whose parents he saw buried. With the priest or pastor, he stood as a bulwark against abortions, divorce, and illegitimacy. Today obstetricians and gynecologists are perhaps best able to fill the same position. Too often, however, obstetric or gynecologic care is limited to the technical problem of the difficult birth or pelvic repair. We are dealing daily with the most intimate aspects of our patients concerning their reproductive activities. It seems to me we are obligated to try to face squarely the frustrations and emotional problems that enter into almost all gynecologic complaints, as exemplified in the case reports given here.

This is not a plea that gynecologists and obstetricians should think themselves into the position of

(Continued on Page 1288)

Medical and Psychiatric Collaboration

Importance and Possibility

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MENTAL HEALTH is the ability to meet and handle problems; to make choices and decisions; to find satisfaction in accepting tasks; to do jobs without avoiding them and without pushing them on to others; to carry on without undue dependency on others; to live effectively and satisfactorily with others without crippling complications; to contribute one's share in life; to enjoy life and to be able to love and be loved. This is not just a matter of chemistry but of training, education and practice in social relations.

Medicine and technology are perhaps the glories of our civilization and culture. Possibilities of industrial production are unlimited. The opportunities of leisure, the arts, physical recreation, the enjoyment of nature, friends and the devotion to others in nonremunerative activities has never been so great. The possibility of freedom from disease has never loomed so bright.

But what on the debit side? The darkness of the depths and recesses of mental illness does not receive the light, the warmth, the help of human understanding which we possess, nor the interest of fellowman which is healing, nor the financial resources without which adequate treatment cannot be given. The plight of the mentally ill in our public hospitals is catastrophic, both financially and from the point of view of the suffering of patients, families, relatives, children—the future citizens. Six or ten million dollars for research in mental illness is small change compared with 180 millions for general medical research, when 51 per cent of the hospital beds of our country are devoted to mental illness, when only 5 per cent of doctors are looking after patients in these beds, and when there are eight to twelve million people in need of psychiatric care. A five billion dollar financial involvement and burden yearly should not be treated lightly. Twelve million children will sometime in the course of their lifetime be relegated by our society to mental hospitals. That is larger than the population of Norway, Sweden, Denmark, Switzerland, almost a quarter the size of England and France. Can we afford such complacency? These are ulcers in our social body that psychiatrists believe, in significant measure, can be healed and even prevented. We ask you and society to help in the healing.

The form and appearance of the American population is changing. Medicine through its triumphs has enabled people to live longer. There are thirty-three million people over fifty years of age and seventeen million over age sixty. Yet, American society has not looked with warmth and favor on older people. America is the country of the youthful, driving successful people. Industry has not yet made places for the aging population. Industry thus is in cultural conflict with medicine. Crowding and urbanization have made it difficult for the older people. Crowded nursing homes are not the answer, and neither are mental hospitals to which many of them now are sent. Enfeebled intellects in the elderly should not be met by mental hospitals. Unfortunately, this is the drifting, complacent outlet or terminus in many instances. Some mental hospitals have 30 per cent of their population in the elderly arteriosclerotic and senile conditions. The aging population does not need primarily psychiatrists and physicians. They need nurses, of course, new kinds of social workers, new types of counsellors and visitors, vocations, hobbies and recreation.

The extent of emotional and mental illness and its problems is significant and on the increase. The statistics at present are that one out of twelve babies born in this century will suffer severe emotional disturbance so that at some time of life it may enter a mental hospital. It is estimated that there are between nine and thirteen million people with nervous, mental or emotional troubles. There are a million patients in our six hundred mental hospitals each year. The resident popula-

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tion is about three quarters of a million. Admissions are around 350,000, of which over 100,000 are re-admissions, with over 200,000 new cases. A quarter of a million patients are discharged each year. This figure is increasing, as are also the admissions. Increases seem to be occurring in the senile and arteriosclerotic groups, the alcoholic and probably also the schizophrenic. There are, of course, no figures on the neuroses in our population nor on the psychosomatic disorders, nor character neuroses or psychopaths. Halliday spoke of the lessening in Britain and Scotland of various social "evils" before the last war, such as improper feeding, impure milk, contaminated water, food which was not fresh, and poor housing. There has been improvement in the death rate, infant mortality, life expectancy, decrease in infectious diseases and increase in height and weight of children. On the other hand, he felt that the psychologic health had been worsening. As indices of community psychologic ill health or social ill health, he pointed to a rise in the infertility rate, the suicide rate, the noninfectious arthritic rate, the gastritis-peptic ulcer, exophthalmic goiter and diabetes rates.

There are 17,000 suicides annually in the United States. There are 7,000 murders. There were 1,800,000 eliminated from service in the last war because of emotional difficulties. We have 3½ million problem drinkers. There are 300,000 severe alcoholics. There are 50,000 narcotic addicts. There are about two million serious crimes committeed each year. Over a quarter of a million children pass through the juvenile courts each year, and the delinquency rate is rising. There are almost 400,000 divorces.

Costs are staggering. Approximately one third of the budget of one of our larger states goes for the care of the mentally ill. State governments pay 560 million dollars per year; the Federal government spends 598 millions, including pensions, for psychotic conditions. This makes a billion dollars. Add one billion for loss in tax dollars and three billion for loss of productivity. This makes the mental health bill of the country five billion dollars, which compares well with the larger businesses of the country. For military research, the figure has been a billion dollars, for medical research 180 million, for agricultural research 100 million, for mental health research from 6 to 10 million per year. The salaries paid psychiatrists in mental hospitals are woefully inadequate. As to treatment, what can we expect if the figure allowed for doctors' salaries, nurses, attendants, heat, light, plumbing, painting, food and raiment is around $3.00 per day compared with $12 to $18 a day in general hospitals? Of course there are snake pits. Public education about treatment instead of herding, regimentation and custodial care is necessary. If better facilities are not provided, certain groups will move in and demand better socialized medical care.

Mental hospitals are piling up their population at a rate of 16,000 a year. In ten years the cost of increased facilities for these added patients will be 2 billion dollars. The population is increasing at the rate of 10 per cent in ten years, and the mental hospital admissions have increased 40 per cent in the same period. We are on a treadmill. New methods of handling this problem can and must be developed. A hospital providing intensive treatment for acute cases in one of our states kept patients thirty-two days as compared with 676 days in the usual state hospital. Costs were lessened in the acute hospital to $281 per patient compared with $1,100 per year on the average in State hospitals.

The overcrowding and understaffing in state hospitals are tremendous. In a recent survey of one of the state hospitals in a prosperous area of the country, the hospital was found to be 49 per cent overcrowded. It was 75 per cent understaffed in doctors and registered nurses, and 50 per cent understaffed if nurses and attendants were considered together. It was figured that if doctors covered the patients each day, each patient could be seen for twenty-one seconds. Other comparisons were striking. If we take the figure that one out of twelve children will enter a mental hospital some time in his life, that means that 8 per cent of 150 million people, or twelve million citizens of our country, will at some time be patients in mental hospitals. This means that we are going to carry a nonproductive population larger than countries like Switzerland, Belgium, Norway and Sweden. This represents not just a medical challenge, but a social, economic and humanitarian one. It certainly points to the importance of research.

This may not be just a question of money, comfort or relief of friction and frustration. It may be a question of survival. It is said that in fifty years the United States will have a population

of 200 million people, while Asiatic countries will have two billion. We cannot afford to neglect our natural resources, and twelve million people in mental hospitals in a generation are a wastage of resources. There are indications that not only our concepts of mental illness may need changing, but that also our methods of treatment and prevention need to be reviewed, revised and reconceptualized.

"The statistics of severe psychiatric disorder form but a segment of the mental health problem. They form the background. . . . Every other bed in the nation is occupied by these patients. Stress, strain and emotional upheaval are the substance of which human life and history have been made.* As Dr. Braceland says, it may well be that they are more frequent and oppressing today than ever before, with the competition and mobility of modern society.

"It is not only the psychiatrist who must contend with these forces and the aberrations they bring. 'No man is an Ilande, intire of itselfe,' nor is any profession or industry or any union of men. The welfare of society is everybody's business, and mental health subtends that welfare as powerfully as any other factor generally recognized to do so. The exact stastistics of overt psychiatric disorder, of crime and delinquency, addiction and other social illnesses are legion. In addition there is a mighty aggregation of masked emotional disturbances contributing to disorder relationships, work dissatisfactions, absenteeism, accidents, marital and family problems and physicial illness itself."

These are psychiatric problems, but they are also social and economic ones. They are a medical responsibility also. Nine or ten thousand psychiatrists can never do the psychiatric job of this country. If one-half of them are in state hospitals, it leaves four thousand psychiatrists to take care of the extra-mural psychiatry of a country of 160 million people. One thousand psycholanysts cannot make much of a dent in this problem except through teaching, research, public education and the creation of optimism and public demands for more psychiatrists and facilities. If eighteen to twenty million patients go annually to general hospitals; if over fifty million go to out patient departments, then there are seventy million people in our country who have close contact with physicians, not including the private practice of medicine. If 10 to 20 per cent of these have important and even etiologically significant emotional contributions or complications, then one must add the millions of those seeing private general practitioners, internists, pediatricians, to the twelve million psychoneuroses and psychoses who are in our general population—twenty million people whose feelings, and emotions, are tremendously important, contributing a hazard and handicap to the pursuit of life, liberty, and the enjoyment of health and satisfying activities. In many, perhaps most of the psychologic or psychiatric problems of society, others than psychiatrists must carry the teatment. This throws tremendous burdens especially on the general practitioner, who always has been and should be, I believe, the backbone of medicine.

But medicine is too broad, too complicated, for the individual physician. He needs the collaboration of others — comprehensive medicine requires an interdisciplinary approach — general practitioners, internists, psychiatrists, psychologists, social workers, nurses, health aids, public health and visiting nurses, volunteers, counsellors and clergy. We probably need new professions we have not dreamed of.

If feelings and emotions are so important in the practice of medicine, we need more collaboration of general practitioners and psychiatrists who are supposed to be experts in feelings, emotions and psychodynamics or the experimental factors modifying and motivating behavior.

Frustration of basic needs produces tension whether in the individual or society. If tensions are overwhelming they produce catastrophic illness, such as mental illness, psychosomatic disease or alcoholism. Typhoid fever, tuberculosis and now polio have been largely conquered. Cancer, coronary disease and strokes are the killers. The latter two are tension illnesses, and who knows but that destructive disequilibria in the body may not be basically involved in cancer? Arthritis, high blood pressure and stomach ulcers are on the march. They are disabling forces in our society, in our happiness, in our mental health. They are in part, certainly, tension diseases. It is in these areas that internal medicine and psychiatry overlap and where collaboration sems most profitable.

How treat emotional disturbances, the more or lesss permanent exacerbations of feelings such as we find in anxiety states, neuroses, many psychosomatic conditions, personality disorders, and some psychoses?

Psychotherapy, the guidance of one individual

*The Mental Health and the Community, an address given at the Mental Health Association of Southeastern Pennsylvania, May 28, 1956.

by another when there are emotional disorders, has certain principles which many physicians have known intuitively, and others from experience. It is not esoteric. It involves the healing effect of interest, the relaxing influence of patience, the help of discussion, and the release of talking out and getting things off one's mind.

Psychotherapy is not merely an intellectual exercise as so many think, nor a matter of will power. It is not a transference of ideas from doctor to patient. It is not merely the development of insight. It is not an argument. It is not exhortation or a lesson in morality. It is not a battle of wills. It is not an opportunity for the doctor with his superior wisdom to improse his ideas on the patient, make him feel inferior or humiliated. It is not an occasion for the doctor to express his anger at the patient because of his own frustration in treating the patient successfully.

Psychotherapy is an experience, and as such it is a process of conditioning and growth. Like growth much of it goes on unconsciously and automatically. An automatic readjustment of the emotional and social forces (which have been conflicting and in tension) takes place. Psychotherapy is a social experience, that is, a relationship with a doctor who wants to help his patient. It is an experience, again I repeat, not an intellectual exercise, in which the doctor's attitudes toward his patient are the most important levers of therapy. The doctor should bear in mind certain needs of all people: the need for new experience, for security, for respect and a feeling of individuality, and for responsiveness and understanding from another human being.

With the exhibition of attitudes of patience, consideration, respect and responsiveness the patient will gradually identify with the doctor. The doctor has a scientific, objective approach to overwhelming situations and conditions. He is not overwhelmed. He knows what to do. He has plans of attack, through asking relevant questions and exhibiting certain attitudes. The patient absorbs this point of view through identification with the doctor, and gradually learns to meet problems and difficulties by asking himself the same questions, and using the trial and error approach, with repetition and practice.

The doctor sets the stage where *his* attitudes permit the release of malignant emotional tensions. When understanding of the complexities of the human organism is so much beyond our ken, there is a place for humility.

But getting well is more important than complete understanding of all the causes of the illness. In this connection, may I quote from Lord Grey: "Nothing so predisposes men to understand as making them feel that they are understood."

Understanding, understanding of some of the important concepts of modern psychiatry, of the nature of emotional and mental illness and etiology, can be of greatest influence. Pavlov and Cannon have introduced important concepts for medicine as well as psychiatry. So has Selye. Stress is inextricably interwoven into life. Freud has made more specific the implications of family influences and childhood reverberations into adult pathology. The work of Hebb and his co-workers at Montreal, from the physiologic point of view, forces on us new concepts of "mental" dysfunction. Isolation from the support of customary sights and sounds (stimuli) can produce psychopathology, for example, hallucinations, paranoid tendencies and delusions as are found in the mentally ill or after the ingestion of toxic substances such as mescaline or lysergic acid. Gantt, Pavlov and Liddell have produced neurotic animals by placing them in situations where training and discrimination conflict, and uncertainty and threats continually present themselves. The fascist and totalitarian brain washings and maneuvers to break ego function have used these methods.

Hebb, Liddell, Pavlov, Gantt, Cannon and Selye introduced new concepts of pathology, stimulation to our understanding, and a challenge to our research and therapeutic resourcefulness whether physiologic or psychologic. We are in a new world in psychiatry and medicine just as atomic science has introduced a new era in living and international tensions. As Toynbee asks, "Can we develop adequate response to the challenge?"

The discovery, mobilization and implementation of new resources in people, whether by chemistry and ataractics, kindness or constructive cooperativeness, are important. Probably many more people have recovered from serious mental and emotional illnesses by ministrations of friends and relatives and perhaps the fortunate turn of circumstances than we have any idea of. There is probably a whole realm of psychiatry beyond that of known statistics.

Research in psychiatry can be stimulated and

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Value of a Department of Physical Medicine and Rehabilitation in a County Hospital

By Stanley Olejniczak, M.D., and
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PHYSICAL medicine and rehabilitation is one of the newest medical specialties and is recognized as an integral part of medical practice. The concepts and techniques of the specialty are now being taught in many of the medical schools in the United States. The American Board of Physical Medicine and Rehabilitation was established in 1947. Growth of the specialty was accelerated during World War II when physical medicine became a major service in the hospitals of the armed forces and in other governmental institutions.

Physical medicine employs physical agents in the diagnosis and treatment of the disease. As the specialty has developed, it has come to include the fields of physical therapy, occupational therapy and rehabilitation.

Physical therapy utilizes physical and other effective properties of light, heat, cold water, and electricity and employs different forms of therapeutic exercise, massage and manipulation.

Occupational therapy is medically prescribed. It not only tends to improve the functional ability of the patient, but also gives him a knowledge of productive hobbies and trades.

Rehabilitation involves teamwork. It employs various forms of physical medicine and psychosocial adjustment and retraining. Its goal is to achieve the maximum functional independence and to prepare the patient physically, mentally, socially, vocationally and economically to lead the fullest life possible within the limits of his disabilities.[1]

There is a growing need to establish more departments of physical medicine and rehabilitation in institutions caring for the chronically ill and disabled. Recent advances in medicine and surgery have been accompanied by a steady increase in the number of permanently disabled people whose lives are saved. With saving of increased number of lives, life expectancy has increased. Two thousand years ago the average length of life was about twenty-five years. At the turn of the century it was forty-nine years. Today it is sixty-six years. In 1900, one person in twenty-five was sixty-five years of age or older; it is estimated that in 1980 the ratio will be one in ten.[2]

In 1910, 26.5 per cent of the nation's population was over age forty-five and required more than one-half the nation's medical services. By 1980 it is estimated that the number of persons over forty-five will constitute nearly one-half of the population.[2]

The increasing number of older people in our population makes the problem of chronic disease continually more pressing. It is estimated that there are over seven million persons in the United States disabled by diseases of the heart and arteries; 6,850,000 with rheumatism and arthritis; 2,600,000 with orthopedic conditions.[3]

During World War II, 19,000 amputations were performed among our military personnel but over 120,000 major amputations were performed during the same period among our civilian population.[3] It has been estimated that 2,500 men became paraplegic as a result of the war, while 15,000 civilians became paraplegic during the same period.[4]

Since the majority of patients in a county hospital are in the older age group and chronically ill and disabled, it would seem extremely important that a department of physical medicine and rehabilitation be established in these institutions. This new medical specialty concerns itself with dynamic medical and psychosocial care. Many chronically ill and disabled patients who receive such care are restored to a high level of physical and mental function. Although a department of physical medicine and rehabilitation in a county institution would provide treatment for patients with acute conditions, it is mainly concerned with

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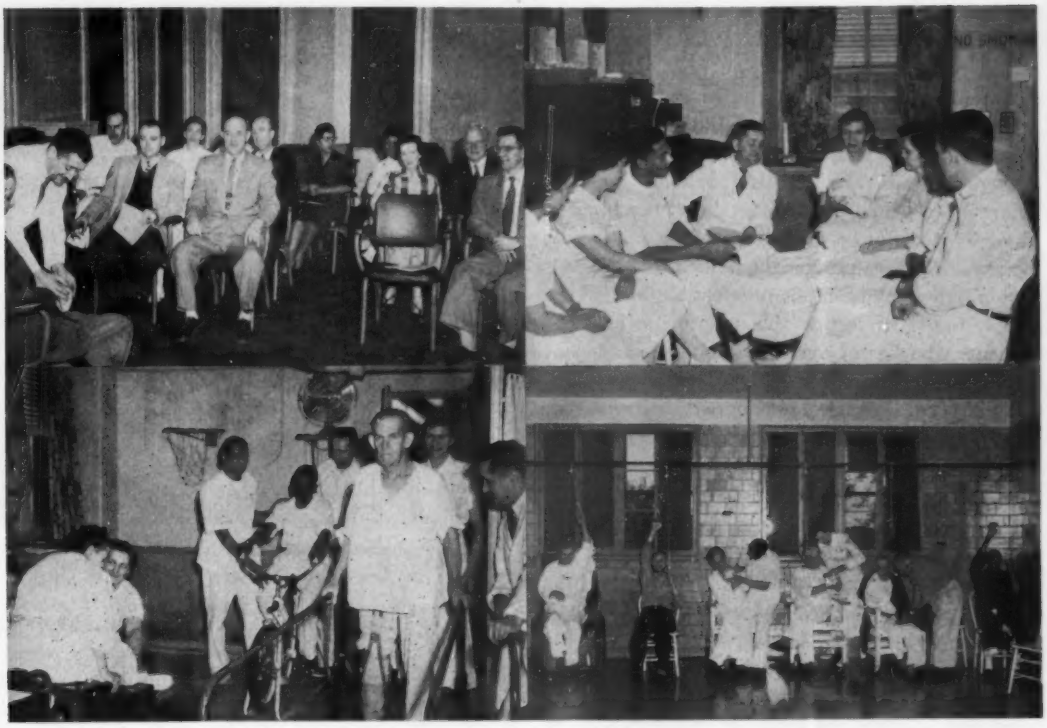


ACTIVITIES IN THE DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION

rehabilitating patients with chronic disease. The department could furnish therapy that would lead to return of a normal life in the community, of a significant proportion of the chronically ill and disabled, now vegetating in our county institutions; at least it could develop in the minds of many of these patients a higher level of self-sufficiency and independence. Patients sent for custodial care could be screened on admission to determine if they might be rehabilitated. Successful screening procedures and proper rehabilitation techniques would reduce the cost of care of these patients and lessen the demand upon the limited number of professional personnel.

A department of physical medicine and rehabilitation in a county hospital could conduct educational programs with actual demonstrations to stimulate agencies and organizations in the community to develop social services and work opportunities for the disabled. By educating the community to new concepts and methods of rehabilitation it should make it easier to return larger numbers of patients to the community to become self-supporting and self-sufficient.

In the Department of Physical Medicine and Rehabilitation at Wayne County General Hospital, the major objective is complete physical rehabilitation, which means training the patient in the activities of daily living for complete functional independence.

In this program the psychosocial problems are investigated and, if the patient is employable, arrangements are made, in conjunction with the Office of Vocational Rehabilitation, for vocational training or for job placement. If, however, a patient in the older age group does not desire to work or if employment is not feasible, the home situation is explored and the members of the family are properly informed of the disability and, in many instances, patients are accepted by their families after completion of the program in the Department of Physical Medicine and Rehabilitation. In every case in which the home situation is favorable, even if the patient is severely disabled, the family is informed of the progress of the patient and the possible date of his discharge from the hospital so that the proper arrangements can be made in advance for taking the patient back

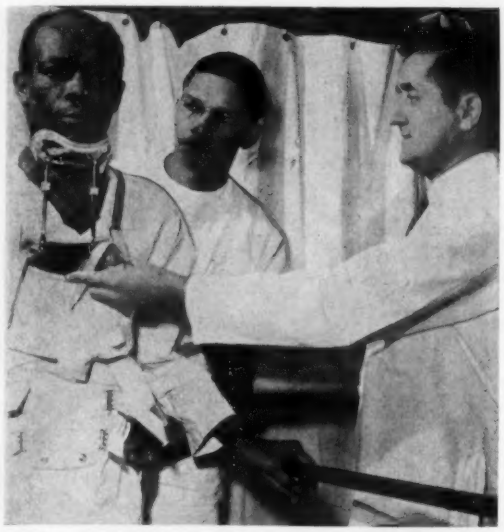
into the home. We try to stress the role of the relatives in meeting the needs of the patient. Even if the patient is able to stay at home for only a few months, we feel that the program is worth while. If the period of hospitalization is too long, the family may lose interest in the patient even though he has regained his functional independence or requires only minimal assistance; even though he easily be taken care of by his family, he may become a permanent resident of the institution. If employment is not feasible and if the family is not willing or able to provide for him, patients who have been rehabilitated to independence are transferred to a ward for the chronically ill, where much less nursing service is required.

Activities for total rehabilitation at Wayne County General Hospital were accelerated in July, 1955, by the appointment of a physiatrist in charge of the Department of Physical Medicine and Rehabilitation. A rehabilitation team has been organized and weekly conference initiated, with presentation of patients. Evaluations are obtained from the departments of surgery, medicine, psychology and social service; the patients are presented and their problems discussed at the conference and realistic program of rehabilitation is outlined.

Since inaugurating the program, a number of patients with various disabilities have been successfully rehabilitated, some only physically and others completely. The largest single group consisted of amputees. In twenty-nine patients the amputation was below the knee, five bilaterally below the knee, and ten above the knee. Two amputations were the upper extremities, one above the elbow amputation, and the other below the elbow.

Three paraplegics were successfully rehabilitated after gaining functional independence in activities of daily living with the aid of braces, crutches and wheelchair. They were discharged home and now two are awaiting to return to work in a factory, and one to enter shelter workshop for vocational training. Another paraplegic, who also walks with braces and crutches for short distances and has a good home situation, was sent to business college. He is provided with hand controls for his car and drives fifty miles to attend classes every day.

Recently a quadriplegic, with a spinal cord injury at C-6 level, was discharged to her home to assume some of the responsibilities of housewife and mother. She was trained to perform some



Rehabilitation patient treated at Wayne County General Hospital.

activities of daily living and to control bladder and bowel function, and was furnished with a wheelchair and hydraulic lift. She had no active motion in either hand. Her brachioradialis was utilized for closing and opening of the hand by extension of the wrist after insertion of a bone block between the first and second metatarsal bones, fusion of the interphalangeal joints in slight flexion, and tenodesis of the flexor digitorum longus and attachment to the radius. She was provided with a splint for the left hand, and after being trained was able to feed herself, brush her teeth, comb her hair and even write.

Several hemiplegics that were discharged from the hospital were provided with short or long double upright braces for the involved lower extremity and a special sling for the involved upper extremity.

We have found that it is important to start patients on a program of rehabilitation as early as possible. Patients usually go through a period of psychologic readjustment to their disability. If realistic programs of physical rehabilitation are instituted soon after the acute phase, the adjustment period is usually shorter and more successful. The patient undergoing rehabilitation, if properly motivated from the beginning, thinks of how to live with his disability and how to make the most of what is left of his functional abilities. If a patient, after the acute phase of injury, is placed on a ward

for the chronically ill and rehabilitation postponed, he may gradually become dependent on institutional life, losing all incentive. Leading a dependent life, the patient's disability may gradually increase in severity. For example, contractures of soft tissues, weakening of muscles or decubital ulcerations may develop. These complications retard the process of rehabilitation. Many paraplegic and hemiplegic patients and amputees have been hospitalized for many years at Wayne County General Hospital and have adjusted themselves to institutional life. They have contact with the outside world by radio and television. A forty-year-old paraplegic with injury of the cord at the level of the 10th dorsal vertebra has been hospitalized for twenty-eight years, twenty-one years in this institution. He is almost constantly in bed and only on special occasions has he been able to sit in a wheelchair. He has developed subluxation and complete fusion of both knees. After several fractures, one of the lower extremities was amputated. Through the years he has had numerous decubiti. He is above average intelligence, but when approached with a definite plan for rehabilitation, he flatly refused, stating that he was too old and would not be able to accomplish anything. His situation results from doing too little, too late. There are other hemiplegic patients and amputees who have been hospitalized for shorter periods, who have the same attitude towards possible rehabilitation. They are all afflicted with the same type of "hospitalitis." Many attempts have been made to work with these patients to make them more independent and although they have agreed to start the rehabilitation program, they have put little effort into it. Many times when improvement in function was noted, the patient would immediately refuse to continue the program and would start to have various complaints. Investigation of these complaints usually resulted in negative reports.

We may cite one case to illustrate how the Department of Physical Medicine and Rehabilitation can screen patients who are sent to the institution for custodial care to determine which ones may be successfully rehabilitated or at least made functionally independent.

A thirty-three-year-old woman was sent to Wayne County General Hospital from another institution after being hospitalized there for six months for custodial care. Her diagnosis on admission was transverse myelitis of unknown etiology with involvement of all extremities. She had a sacral decubitus about 5 cm. in diameter and had no control of bowel or blader function. The patient was on a Stryker frame. A careful examination revealed all muscle groups in the extremities were at a fair minus to fair level. A program was instituted to re-educate her and strengthen her muscles. Training of bowel and bladder control was begun. Gradual ambulation was started after endurance in sitting and standing was improved. The patient was very difficult to manage and uncooperative at the beginning of the program and would not even feed herself, stating that she had no hope for recovery. However, when she was removed from the Stryker frame, she was persuaded to feed herself in the sitting position. She was informed of the possibility of her becoming independent and of returning to her family. The patient then became more cooperative and put more effort into the prescribed exercises and activities of daily living. After three and one-half months on a program of rehabilitation, the patient regained bowel and blader control and was able to ambulate with crutches. She gained fifteen pounds in weight. The sacral decubitus gradually healed without the necessity for surgical intervention. On a return visit, one month after discharge, she stated with tears in her eyes that she was the happiest person in the world, because she was now able to take care of her children and be back with her family.

Rehabilitation can be successful even in the most severely disabled patient, if the program is planned realistically with practical goals.

A patient, a forty-three-year-old white man, who had been afflicted with multiple sclerosis since the age of eighteen, was referred to the department from the Infirmary Division. With progression of the disease and confinement to bed over the years, he had developed severe spasticity and gradual paralysis of both lower extremities, severe flexion contracture deformities and a dislocation of the left hip. Both his legs were flexed in a fixed position on his chest with knees almost touching his chin. He had lost bowel and bladder control, necessitating the use of a perineal catheter. A large sacral decubitus had developed. Disarticulation of both lower extremities at the hips was carried out. Following surgery, the patient started to use a wheelchair, participate in social life, move around and visit with older patients. To the casual visitor he was the happiest man in the world, always smiling and joking. To increase his activities it was decided to change the perineal catheter to the suprapubic area. The sacral decubitus is healing gradually and after debridement it appears that no other surgical procedure will be necessary. The patient is being trained in wheelchair activities and to participate in activities of daily living with the goal of attaining full functional independence. Plans are being made for this patient to return to his parents' home. He will be provided with a special wheelchair, a bedside commode, and an overhead bar. He will re-

quire very little assistance, whereas previously it was impossible for his parents to care for him at home. Since he had some experience in drafting, the Office of Vocational Rehabilitation is planning to assist him in obtaining a homebound job.

The chief function of a Department of Physical Medicine and Rehabilitation in a county institution is to attempt to obtain total rehabilitation of the physically disabled through integration of different services. It is necessary to a "team" approach among the personnel working with the patient.

Patients who successfully complete programs of physical rehabilitation are either sent back to their previous jobs or placed on job training in order to become productive members of society. Elderly patients who cannot be re-employed, even though they have gained physical independence, can be sent home or to nursing homes to lessen the burden of nursing care in the hospital.

Successful programs of rehabilitation will release beds for new patients which is vital to the institution and means savings of thousands of dollars to the community. The human aspects of rehabilitation, such as restoration of dignity, self esteem and happiness, cannot be assessed in dollars.

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BEHAVIOR PROBLEMS

(Continued from Page 1270)

turn because of faulty administration of their medicine by relatives and friends—none had gone to their family doctor as we had recommended.

It is within the power of each of you to further the work that we, in your state hospital system, have undertaken. We have broken the treatment barrier so that you can now successfully control, ameliorate or reverse most of your abnormal behavior problems.

Therefore, I ask you individually, and as a Society, to consider the problems of prevention and follow-up, and the part you can play in making this a better world in which to live.

PSYCHIATRIC ASPECTS OF GYNECOLOGIC CARE

(Continued from Page 1279)

pseudopsychiatrists. Many of our cases do need experienced and trained psychiatric care; these we should be quick to recognize. Many more, however, are desperately looking for the kind of sympathy and understanding, the psychologic support given by the old-fashioned family physician, and this is the help we are in a favorable position to offer. Recognition of this by those in our specialty may, in the long run, become the greatest contribution any group of clinicians can give to the mental and physical health of the women of our country.

The Importance of Differentiating Petit Mal from Other Forms of Minor Seizures

By E. Rodin, M.D.
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THE introduction of electroencephalography as an aid to neurologic diagnosis has helped considerably to differentiate various forms of minor seizures. Prior to the use of electroencephalography, the term petit mal was employed to cover a wide variety of epileptic seizure phenomena which last only a short period of time, usually up to three to four minutes. The increase in knowledge about seizure patterns and their presumed origin has allowed the separation of various groups of minor seizures. The two largest groups are true petit mal and minor seizures of the "psychomotor" or "temporal lobe" variety. The patients who belong to either group are usually sufficiently different in their clinical manifestations, electroencephalographic findings, etiology of seizures, prognosis, and response to therapy, so that the clinician should try to make an accurate distinction between them. The main differences are summarized in the accompanying table. Since neither of the terms "psychomotor" seizures or "temporal lobe" seizures is completely satisfactory, both terms are used at present more or less synonymously.

TABLE I. DIFFERENTIATION BETWEEN PETIT MAL AND PSYCHOMOTOR OR TEMPORAL LOBE SEIZURES.

DIAGNOSTIC CASES	PETIT MAL SEIZURES	"PSYCHOMOTOR"—"TEMPORAL LOBE" SEIZURES
Aura	None	Frequent, consists of a great variety of somatic, visceral or sensory phenomena
Consciousness	Lost or severely impaired	Lost or severely impaired, but at times retained. "Mental Diplopia"
Motor Activity	None or some jerking of eyelids at the rate of three jerks per second. At times also rhythmic jerks of the head or arms	Chewing, smacking or swallowing motions, performance of complex automatic acts. At times no motor activity visible
Duration	10-40 seconds	1-2 minutes
Postictal	Patient is fully oriented may be amnesic for seizure	Is confused, drowsy, possibly aphasic, may be amnesic for seizure
EEG: During seizure	3c/s spike-wave in all head areas	Seizure pattern complex, either high voltage 6c/s activity most pronounced in the temporal areas, or focal slow wave activity in temporal areas, generalized slow wave activity. And other types of seizure patterns
EEG: During interval	Frequently minor	Usually focal abnormality in one or both temporal areas
Etiology	Hereditary, idiopathic	Usually acquired, although hereditary factors may be present in addition
Age of onset	Around three years	All ages, but more frequent in adolescence and adulthood
Interictal emotional disturbances	Frequently normal	Frequently marked
Most effective drugs	Tridione, Paradione, Milontin, Amphetamines, Diamox	Dilantin, Mesantoin, Phenurone, Mysoline, Phenobarbital

The petit mal seizure is characterized clinically by abrupt loss or diminution of awareness, which interrupts the patient's stream of thought or motor activity for a period of ten to forty seconds. The patient may merely have a vacant staring expression of his eyes or there might be in addition some slight blinking of the eyelids, at the rate of three blinks per second. In other instances there may also be some visible nodding of the head or mild to moderate bilateral jerkings of the arms and, occasionally, the legs. This is usually also at the rate of three jerks per second. The seizure ends abruptly and the patient immediately afterwards continues what he had been doing prior to his attack, without mental confusion.

The electroencephalogram reveals during the seizure the classic 3c/s spike-wave pattern described by Gibbs and Lennox in 1937. This usually starts suddenly in a bilaterally symmetrical and synchronous manner involving all head areas, and terminates abruptly when the patient becomes responsive again. The more pronounced the spike component of the discharge (especially if multiple spikes are present which are followed by a wave), the greater the likelihood that the previously men-

From the Neuropsychiatric Institute, University of Michigan, Ann Arbor, Michigan.

tioned clinical myoclonic components of the seizure are pronounced or that the patient suffers in addition from grand mal convulsions. The patients with petit mal, as defined here, are usually children or young adults and are as a rule extremely sensitive to such activating procedures as a period of hyperventilation, small doses of Metrazol, or intermittent photic stimulation. The sensitivity to hyperventilation is usually to such a degree that this may be conveniently demonstrated in the clinician's office and a positive diagnosis can be established, even without electroencephalography, on basis of the typical clinical picture alone. No other seizure type is as easily reproduced by a two to three minute period of deep breathing as is petit mal.

While petit mal seizures are thus reasonably simple in their pattern, the "psychomotor" or "temporal lobe" variety of minor seizures is frequently rather complex. The attack may start with immediate loss of consciousness or, more frequently, with an aura. The aura—which is, of course, actually the onset of the seizure—may consist of a variety of visceral sensations, the most common being a knot or lump in the stomach which rises to the throat. Following this there is frequently dizziness, which may be a sensation of lightheadedness or of impending blackout or may be a true subjective or objective vertigo. After this, loss of consciousness frequently ensues. In other instances, the patient may experience a sudden fear sensation before blacking out or may be aware of alterations in space perceptions, of a dreamy sensation, or have an olfactory, visual or auditory hallucination. The patient may remember these clearly after the attack or may only be aware of having had a hallucinatory experience the content of which he is unable to recall. During the attack the patient usually retains his posture; he may continue his activities in an automatic fashion or may "freeze" to a chair, table, or kitchen stove. There are, frequently, lip smacking, chewing motions of the jaw, and swallowing motions. These may be very pronounced or only faintly visible. Other motor activities, if the patient does not remain "frozen," may include repetitive and rather purposeless movements of the upper or lower extremities, such as plucking at clothes, waving an arm, stamping a leg, or the like. The variety of these acts is practically infinite in the various patients, although the seizures are usually alike in any given patient. This phase of the seizure lasts, usually, one to two minutes during which time the patient is totally unresponsive.

Following this, the patient becomes gradually more responsive and during the recuperation is likely to show signs of mental confusion, drowsiness or nervousness. The patient may be physically or verbally abusive, may complain of a headache and, if the seizure arose in the dominant hemisphere, frequently exhibits a noticeable aphasia. This consists initially of a complete inability to talk and an inability to name objects; if the patient can say anything at all it is fill-words like, "ah, ah," "yes," "you know," "shucks," and the like. Later, as cerebral recovery progresses, the patient becomes more fluent but may still be confused as to time and place. This postictal state lasts up to five to ten minutes. Although one is able to communicate with the patient during this time and may even receive seemingly rational answers, especially if there is no aphasic component, the patient may later have complete amnesia for the entire sequence of events and ten minutes later may even vigorously deny having had a seizure at all. In other instances, there may be amnesia only for some aspects of the seizure and, especially during a "dreamy state" or hallucinatory experience, the patient may be aware of his surroundings as well as of the content of the hallucination. This is the state which Hughlings Jackson termed "mental diplopia."

The electroencephalogram during one of these attacks shows a variety of seizure patterns. There may be a high voltage 6c/s rhythm present, most pronounced in the temporal areas, or diffuse slow wave activity or focal spike and sharp wave activity may appear in one temporal area. At times the electroencephalogram may be so distorted by movements of the patients that the seizure patterns can not be seen clearly at the time of the attack; but during the postictal confusion state there is frequently a pronounced slow wave focus in the temporal area on the side where the seizure arose. This slow wave focus may persist up to several hours, depending on the severity of the seizure. In contrast to patients with petit mal, who frequently have normal interictal records, the electroencephalogram in the majority of the "psychomotor" or "temporal lobe" seizure patients shows abnormalities, usually located in one or both temporal areas, even in the resting state. Hyperventilation is not as effective in producing a seizure as in petit mal, and if a seizure is precipitated it

usually does not occur during the hyperventilation effort but rather about thirty to sixty seconds after cessation of the overbreathing. While petit mal occurs usually in children and adolescents, psychomotor seizures occur most commonly in adolescents and adults, although no age is immune.

If the above criteria are kept in mind, a differential diagnosis can usually be established on clinical grounds alone. It may, however, be difficult to differentiate some minor seizures of the "temporal lobe" variety from hysterical attacks. This difficulty is increased markedly if the seizure shows only minimal or atypical motor components and especially if it does not pass through the entire sequence of events described above but ends, for instance, after the aura. In such cases, it is highly important to observe an attack in the laboratory while the electroencephalogram is recorded. Seizure patterns in the electroencephalogram during the attack are diagnostic of the convulsive nature of the disturbance.

The differentiation of petit mal from other forms of minor seizures is not only of academic interest, but is also of immediate concern for the management of the patient. Petit mal, with or without grand mal convulsions, is nearly always on a genetic hereditary basis and almost never on the result of birth injury, encephalitis, brain tumor, or trauma. The hereditary factors may not be obvious if one directs attention only to the presence or absence of grand mal seizures in the siblings and parents but they become soon apparent if habitual fainting spells, febrile convulsions, "worm fits," seizures after alcohol ingestion, et cetera, are also taken into account. Lumbar puncture and pneumoencephalography can be dispensed with in the classic case.

The prognosis in regard to the disappearance of petit mal seizures in adolescence and early adulthood is fair, although the petit mal attacks may be superseded by grand mal convulsions and, later in life, "temporal lobe" seizures may also develop. As long as there is only pure petit mal present, the intellectual and emotional development of the child is likely to be reasonably normal. Behaviorwise, the patients do not present, as a rule, any marked difficulties unless their seizures come so frequently that one can speak of a petit mal status. The patients may then present, clinically, either a psychotic or a hysterical picture. The drug treatments of choice are: Tridione, Paradione (preferably each of these two drugs should be combined with Dilantin in order to forestall the development of grand mal convulsions), Milontin, Amphetamines, Diomax or Prenderol. A ketogenic diet is occasionally also of benefit. There are no operative procedures available which are of any help.

The other forms of minor seizures have different implications. Any minor seizure which is not petit mal is likely to have demonstrable organic pathology as its basis. Although hereditary factors frequently play a role, there is an equally large factor of acquired pathology. This may be on the basis of birth injury, other head trauma, early encephalitis, a porencephalic cyst, or other congenital malformation in children; of brain tumor, cerebral degenerative, or vascular disease in adult patients. Contrast radiographic studies, like pneumoencephalography or angiography, have to be carried out in many instances for final diagnosis. In children and adolescents the intellectual development may be normal, but more or less severe emotional disturbances are usually present. Hyperactivity, excessive mood swing, unmanageable and unruly behavior, inability to concentrate, temper tantrums, and excessive masturbation are frequently outstanding features. If the seizures also involve the middle and posterior portion of the temporal lobe, with resulting auditory and visual hallucinations, the patient may present a clinical picture suggestive of either severe hysteria or psychosis.

The above mentioned emotional difficulties are also commonly seen in adult patients with frequent minor seizures of this type and suicide attempts occur often in this group of patients. The prognosis of spontaneous improvement of the seizures during adolescence and adulthood is rather poor, and most patients are able to make only a marginal social adjustment, despite some happy exceptions. "Epileptic deterioration" is most frequently observed in patients with this type of seizure pattern.

The seizures are often very difficult to control pharmaceutically. The drugs which are relatively effective are: Dilantin, Mesantoin, Mysoline, Phenobarbital, Phenurone, or mixed preparations like Mebaroine, or Phelantin. A ketogenic diet is of no apparent value. If there is a definite unilateral focus, limited to the anterior portion of one temporal lobe, surgical resection of this part of the temporal lobe may lead to good results after medical management has failed. The surgical

approach, however, should be limited to patients with no evidence of separate involvement of the other temporal lobe and where a conservative regime, of adequate medication and a sympathetic psychotherapeutic approach directed toward lessening of tension, has failed.

Summary

1. The difference between true petit mal and other forms of minor seizures is emphasized. True petit mal occurs usually in childhood and consists of "absences" without warning. These last usually between ten and forty seconds and are not followed by mental confusion. During the seizure some rhythmic blinking of the eyelids, nodding of the head, or slight jerking of the arms or legs may be noted. The EEG shows usually a classical 3c/s spike-wave pattern and is frequently normal in between seizures.

2. The most common form of other minor seizures is the "psychomotor" or "temporal lobe" variety. These seizures frequently have a warning. They last about one to two minutes and are followed by a two to five minute period of mental confusion. During the seizure, itself, complex muscular movements may be carried out and a variety of sensations may be experienced, with complete or incomplete amnesia afterwards. The EEG shows complex patterns during the seizure and in the interval a focal abnormality, involving one or both temporal areas, is frequently present.

3. Petit mal is one of the classic forms of "idiopathic" or "genetic" epilepsy. Lumbar puncture and pneumoencephalography can be dispensed with if petit mal is present alone or accompanied by grand mal seizures which are not preceded by an aura.

4. Other minor seizures are usually of the acquired type; hereditary factors, if present, are somewhat less important than in petit mal. Diagnostic procedures, like pneumoencephalography and/or angiography must often be carried out to exclude a mass lesion.

5. Petit mal patients do not present, as a rule, overt behavior problems; patients with other forms of minor seizures frequently do.

6. The more useful drugs in petit mal are Tridione, Paradione, Milontin, Amphetamines, Diomax and Prenderol; other forms of minor seizures respond better to Dilantin, Mesantoin, Mysoline, Phenobarbital or Phenurone. If all medical management has failed and if the focus of pathologic activity is limited to the anterior portion of one temporal lobe, surgical ablation of this area may be of benefit.

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MEDICAL AND PSYCHIATRIC COLLABORATION

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facilitated by physicians. It has lagged far behind other branches of medicine.

Psychiatrists and physicians can collaborate in treatment. Beyond this they can help to change the public attitude toward mental and emotional illness which to a great extent is understandable, curable, and preventable. Physicians can help remove the stigma that is a primitive, prerational, cultural inheritance. One only has to think of Adams, Jefferson, Lincoln, Newton and Darwin to realize that severe emotional disturbances do not occur alone in weaklings.

Finally, a benevolent tolerance, criticism and helpfulness in the realization of the great handicap under which psychiatrists, especially in public hospitals, labor will help relieve or lighten a staggering burden which our society is often needlessly carrying.

Medicine and Labor in These Changing Times

By Walter P. Reuther
Detroit, Michigan

YOUR INVITATION to contribute this year's installment to the distinguished series of Biddle Lectures before the Michigan State Medical Society comes as a signal honor to me as an individual and to the Union I represent, the United Automobile Workers. As an individual, I shall always be profoundly grateful for the fact that in 1948, after being almost mortally wounded by a shotgun blast through the window of my home, I was put back together again. I know it was only through the skill and dedication to service of the physicians who gave my case immediate attention, in many cases at great inconvenience to themselves, that I am not only still alive today, but can function as a physically whole person. For the rest of my life, I shall carry with me great respect, affection and appreciation for the many doctors whom I came to know as a patient during those critical days.

I share with many Americans a deep sense of how much better life has become as a result of the striking advances in medicine. Millions of people are today living with diseases that would have meant certain death only a few decades ago. The major infectious diseases have been virtually conquered. Rehabilitation of amputees and paraplegics borders on the miraculous and offers new hope for millions of victims of the major chronic diseases. Almost certainly there lies ahead a break through in our understanding of how cancer destroys the processes of life, the discovery of new methods for the detection and treatment of cancer and heart disease, and the application of new tools and understanding to the conquest of mental disease. These must be challenging and rewarding times to be a physician.

These advances have made modern medicine inherently more expensive. The worker has had to find ways to allocate more money to health care, to pay and arrange for it in advance and to share its cost. Health insurance has become nothing less than essential and its further development inescapble. And in the process, labor and medicine have become more dependent on each other than ever before.

I think it can be said fairly that while medical societies may have entered prepayment reluctantly in order to avert government medicine, labor entered voluntary health insurance reluctantly because a government program was not available. The original motivations of both medicine and labor are now of only academic interest. What is far more important is that both are actively involved in prepayment and our common problem is to make it work.

To accomplish this we face some troublesome and unsettled questions—the scope of health insurance; setting of fees and methods of remuneration that are adequate, on the one hand, and equitable on the other; finding ways for health insurance to contribute to the best development of good medical care. Whenever two groups are thrown together as are medicine and labor some friction will be generated. I am not too worried about the friction generated by these problems. I hope that this meeting will lead to a better understanding between organized medicine and organized labor. Such understanding is absolutely essential for the fullest development of medicine and for the sound financing of health care.

I would like to tell you a little about unions, because I fear that normal sources of information in the community often do not give an accurate or balanced picture of the trade union movement.

Through most of history the balance has been heavily weighted against the working man as an individual. Workers came to organize unions in order to get a better share of the good things of life. Only through association could he aspire to make real economic progress not only on the wage front but in terms of the broader gains of economic security, justice and dignity.

Unions are now looking at the length of the

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Inasmuch as Mr. Reuther, because of illness, could not be present at the session for which the lecture was scheduled, his address was read by Leonard Woodcock, vice president of United Automobile Workers.

work week and again, as when labor campaigned to reduce the twelve hour day, we find that leisure is supposed to be O.K. for others but that it leads merely to licentiousness in workers. Evidently, this is one argument that hasn't changed much with the times. As wage payments are not enough to assure economic security when the worker is too old or unable to work, labor turned to various forms of social insurance—pensions, when the worker became too old to work and too young to die; unemployment insurance, guaranteed annual wage plans, compensation for work injuries and other such programs. It was necessary to protect the worker against hazards to his health and safety on the job and this was why some of the early labor health centers were established.

I think that our Union in particular draws its effectiveness and inherent strength not only from struggling for a better life for its members but from its moral concern that labor's gains must be accomplished together with, and not at the expense of, the community. Our members today have cost-of-living elements in their pay. We, nevertheless, are concerned with the rising cost of living. It was no publicity stunt when last month I called upon the presidents of the major automobile companies to join with us in the first steps to reverse the tide of inflation.

It is possible to make economic gains without democracy and in some parts of the world advancement has been achieved at the expense of freedom. One of the great challenges of today is to prove the compatibility of economic security and political liberty. I believe our union to be the most democratic in the world. Our members are free to criticize and they do criticize; our members can remove their leadership, and they do it at times; our members can reject proposals advanced by their leadership and they do so; and recently we have created an independent body entirely outside of the union structure to which members can have recourse with their complaints about the union.

We have, it is true, pioneered in many new social programs through collective bargaining; pensions, supplemental unemployment benefits, higher levels of disability protection and so forth. Almost every one of these programs was originally characterized as "destructive of the American way of life." All are now regarded as worthwhile to the worker, good for the company, helpful to the economy and good for the country as a whole. The fact that society now acknowledges the value of past gains has not inhibited many people from criticizing each new proposal in the same old way. Practical bargaining gains like these that have been hammered out over the bargaining table reflect the best joint thinking of management and labor and have made a great contribution to the prosperity of America. Be assured that this progress is not at an end.

Our position also derives its strength because demands advanced in collective bargaining arise out of workers' basic needs. Ultimately the contribution of labor leadership depends on its ability to know what workers want and need as accurately as possible. When the UAW takes a position on a large issue it does so only after it has made a careful study of the problem and after the issues have been thoroughly considered and debated by a convention of over 3,000 delegates, freely elected by secret ballot from among the rank and file of the Union. Our collective bargaining negotiations with the major automobile companies are preceded by a whole series of meetings at which elected delegates from plants all over the country have had an opportunity to discuss and act on these demands.

However much the newspapers, may criticize each new demand that the Union makes, the fact is that once the membership, through democratic processes, decides that demands arise out of real needs and they are economically sound, they will back them up—even at great sacrifice. In 1950, when the Chrysler Corporation refused to provide funded pensions, the Chrysler workers stayed out on strike for 104 days to nail home this issue of funding. And when Henry Ford II insisted that the workers would prefer a stock participation plan instead of the guaranteed annual wage that they were demanding, the Union quickly offered to put the question to a test by secret ballot. At this point, Ford management promptly withdrew its proposal and began to bargain in earnest.

I am little concerned about the lack of understanding on the part of some in medicine toward labor and a tendency to disparage the legitimate objective of the trade union movement. The president of a local medical society recently attacked our proposal for a shorter work week. He said this was leading in the direction of a "no work week" and characterized the objective of union-

ism as "security, idleness and play." As for security, millions of Americans, including doctors, want and need ecomonic security. Security isn't their only goal but it is an important one. It doesn't rank first and neither do idleness and play rank second and third for any group of thinking Americans, including unionists. American labor is not only concerned with a fair share of economic gains for the working man but, with all Americans, we are concerned with the great problems of peace, abundance and democracy. If the medical profession accepts only a caricature of these aspirations it will only harm itself in failing to understand the issues that motivate the majority of the people. If it tries to understand these motivations it will realize that the quest for security is not at odds with medical practice any more than is the quest for health. People need good programs of economic and health security. Such programs can be worked out in a manner that will enhance medical practice rather than harm it and to the satisfaction of the medical profession as well as to the public at large.

When workers have complaints about their medical insurance they are more likely to come to the Union that has negotiated the insurance plan than to the Medical Society. Our members bring us many complaints about medical insurance. The worker wants to know why, after paying his premiums, he has to lay out substantial amounts to the doctor when he has an operation. He wants to know why he can get x-ray tests only when hospitalized. He wants to know why so many medical services are not covered by insurance. He wants to know why the insurance so often fails him in serious illness.

The Union screens out unjustified and excessive demands for service. It plays a very important role in telling the worker, in relation not only to his insurance but to his labor-management contract rights—when his demands and grievances have no merit or cannot practically be realized or corrected. But I cannot conscientiously quarrel with union members when they want prepayment to cover a bigger segment of health care for a longer period of time, and not be limited to bills for the hospital and the surgeon, or when they demand real value for their insurance money. These are not ideological problems; they are practical. They can be answered. The question in America, as far as millions of wage earners are concerned, is not whether they are going to have adequate prepayment programs. The question is, "How?"

The president of the American Medical Association recently deplored labor demands for full payment of all items in medical care. He accused labor, by setting this improperly high standard, of disparaging the performance of existing plans. This charge doesn't even come close to the real issue. We are not, as Dr. Allman seems to think, arguing about extending insurance from covering most of the cost of health to covering all of it. Present insurance plans, at best, cover only one-third of the average family's health service bill, and we are trying to get benefits extended to cover about another third of health needs. The present deficiencies, rather than excessive demands by labor, constitute the main problem in health insurance today.

Workers not only want more and better prepaid health coverage but they are willing to pay for it. They know that truly comprehensive care costs more. Although they are concerned with rising costs and with some abuses and inefficiencies in existing programs, they are not trying to reduce doctors' incomes, as has at times been charged.

The fact that employers pay premiums in full or in part has led to the false assumption that workers will make unreasonable demands for health coverage because, somehow, they are not paying for it. They are, because employer contributions are monies the worker could otherwise get in cash or other benefits. This is perfectly clear at the bargaining table, where a certain amount of money is applied to the hourly wage rate, a certain amount to health security, a certain amount to pensions, and so forth. The money that employers contribute to these programs is just wages, in a form to best serve a social purpose. Doctors have made great gains out of the fact that the workers have earmarked a portion of their wages as social wages. This has permitted a greater economic allocation to the cost of hospital and medical care, if only by the fact that in this collective way workers as a whole have been able to pay for medical care that they could not have paid for on an individual basis. The trouble is that this has led some doctors to assume that the insurance has increased the worker's ability to pay, and they charge more for their services. As a result, we have found that the dollar paid by the employer and the worker

under the health plan is not worth as much as the dollar paid out of pocket at the time the service is performed. Those who are responsible for the development of prepayment must assure the beneficiary that he will receive full value for his prepayment monies, if we are to increase the allocation of our national income to personal health services.

To the extent that medical societies entered prepayment to avert legislation, they were relatively less concerned with finding the best possible way for prepaying medical care. Rather than to hammer out a whole new set of insurance principles that could be properly applied to medical care, they adapted the ready made doctrines of casualty insurance. Inappropriate as they are, they have been sanctified as "first principles" which now conceal the lack of medical orientation of too many of our health insurance programs. I really don't believe that the average doctor, with his deep interest in medical services, is ready to adopt the insurance industry's concepts of losses rather than benefits, indemnity rather than service, financial devices to inhibit use, to eliminate the small claim and to exclude predictable expenses rather than preventive care, early diagnosis and easy access to health services.

I fear that medicine is in danger of compounding these errors when it flirts with major medical programs like that at General Electric. Whatever its current vogue, major medical epitomizes the complete capitulation of medicine to insurance.

A great gap exists today between the advanced state of medical science and the kind of medical care received by the bulk of working people. This gap does not exist in the field of medicine alone. For the first time in the history of civilization we have the tools with which to conquer poverty and hunger and disease and ignorance and man's other ancient enemies. For the first time mankind has the know-how and the scientific and technical tools to master his physical environment. This is the first time that it is no longer necessary for people to be hungry, for people to be naked or for people to be denied the essentials of life. Our great task and the great challenge before the free people of the world is to find a way to harness the power of science and technology, not to make H-bombs, not to destroy human life, but to advance the well-being of the human family.

You can go out into the Ford plant where they can make an engine block in 14.6 minutes. There are no manual operations involved. This plant is already obsolescent. Television sets are manufactured by automation, without a human hand touching the product. On the drawing-boards they have new machinery that will make the equipment they use today look like museum pieces. I was told the other day that there is a machine that can capture the tone qualities from a recording by Enrico Caruso. That machine can sing, with Caruso's voice, a song written twenty years after his death.

This is the world in which we live. Machinery is taking tremendous steps forward in terms of creating greater and greater abundance, with less and less manpower.

Now what are we going to do with this technological revolution? If we gear it to the needs of the people, if we use this power with a sense of social responsibility, we can build a greater new world with all its poverty and hunger and unnecessary suffering from disease removed. Unless we use this power sensibly and sanely in the interests of all of the people, then these machines, instead of building a better world, can dig our economic graves.

This is the problem in America today. The search for new answers must have its application in medicine as well as in all the other fields of man's struggle. While men may differ as to how best to close the gap between our potential and its realization—between the kind of medical care that is within the competence of the medical profession to provide and what is now generally available—we cannot and must not stand still. If progress is to be made, bold experimentation is needed. Old concepts must be re-evaluated and adapted, and new ones must be developed. Many fear change; but change is inevitable.

A wise society, however, tries to guide change in relation to certain principles. In medicine these principles recognize that while practice is firmly based on science, it is still an art. Scientific progress has increased the patient's bewilderment at what is happening to him when he seeks medical care. Far from eliminating the need for a close personal relationship between the patient and his doctor, it has made the doctor-patient relationship all the more important. Where a continuing doctor-patient relationship does not exist, as is now too often the case with many Americans, it should be established. Where it exists it should

be preserved and enhanced. Let me dispel a bogeyman. Anyone who has thought about medical practice knows that it is essential to preserve the personal relationship in medicine. No one would knowingly advocate impersonal, assembly-line medicine. But let us not stretch the valid need for doctor-patient rapport to apply to the way in which a pathologist gets paid for his services. It is very difficult for me to see how the doctor-patient relationship is in any way impaired by the adoption of a modern plan for transferring money from the patient's pocket to that of the doctor.

An improved standard of medical practice is lengthening the already long and arduous period of education through which the modern physician has to go—college, medical school, internship, residency—which can take him into his thirties before he begins to earn a reasonable living. The doctor can never stop studying if he is to keep pace with evolving medical knowledge. We must find ways to increase his opportunities for continuing education and research. Most important, I recognize the weight of life and death responsibility that bears constantly on the physician. Certainly these considerations must be fully reflected in the financial rewards for the practice of medicine.

In all planning for medical care, quality must receive the highest possible priority. Our Union wants no compromise with quality; we are not looking for bargain basement medicine. In this I am sure our aims conform with yours. The arrangements to provide and pay for care must not conflict with the objective of high quality care; rather they must reinforce it. But we cannot accept the contention that quality is automatically lowered by any change at all in the currently prevailing pattern for practicing medicine or paying for it.

In present practice quality may be sacrificed by the heavy concentration on episodic illness to the neglect of preventive care. One of the greatest challenges in medicine is the opportunity to detect cancer and other fatal diseases at a stage when these killers can be easily disarmed. How many doctors are attuned to preventive medicine? How widespread is the application of these new techniques for early disease detection? How high is the unnecessary fatality count today?

It is because I believe we are in essential agreement on broad principles that I am confident we can find solutions to the problems concerning us.

Recent progress in prevailing community health insurance has been too slow. As a matter of fact, there is considerable regression from earlier principles of prepayment. Because of this, pressure has been building up in unions to set up their own medical care programs. Some unions have done so. The Mine Workers have made a great contribution in building and staffing ten modern hospitals and clinics.

The UAW decided not to launch a separate union medical care program. It has taken the much more difficult course of working with the rest of the community. Setting up a union program would be pulling out of existing hospital-medical programs the group that now carries the major share of the financial load. It would fragmentize medical care in the community and ultimately leave thousands and thousands of families in a kind of no-man's land with no real protection. We support the community approach because we believe that labor in a free society cannot solve its problems in a vacuum—that we can make progress only if we co-operate with men and women of good will in the whole community to find answers for the problems of all the people.

We have consistently bargained for and supported community plans such as Blue Cross and Blue Shield. In our negotiations we have not asked for special favors, but have sought to improve the community-wide contracts available to all. The prevailing pattern of our health service benefits throughout the country amply demonstrates our determination to improve and support community-wide plans.

For years we have been urging existing plans to experiment with substantially broadened benefits. As we have said on many occasions, we will support experimentation which is soundly conceived and medically oriented and which effectively removes the economic barriers to medical care. We would hope, for example, that the Michigan Medical Service Plan would provide benefits like those developed under Windsor Medical Service by the Essex County Medical Society in Ontario.

We are also convinced that further experimentation is necessary ; that is why the UAW is backing the development of the Community Health Association which, under medical leadership, will be experimenting not only with broadened prepayment benefits, but also with

medical care organization. In this new program it is contemplated that benefits will be comprehensive in scope including preventive care, and rehabilitation, and that the care will be provided by physicians in group practice. We are not going to coerce people into joining this plan. Every individual in every group will have free choice of plan, so that each family may elect to be a member of this plan or some other program, like Blue Cross-Blue Shield. For over five years, this principle of free choice has been a feature of the UAW's collective bargaining contracts with the auto industry. In California, Ford, Chrysler and General Motors workers individually choose between Blue Cross and Blue Shield on the one hand and the Kaiser Foundation Health Plan on the other. The Union firmly believes that its efforts in the provision of medical care must be to expand choice, not restrict it.

Earlier this year, more than forty prominent physicians, about half of them from Michigan, came together at the invitation of the CHA to advise on how to establish and maintain a high level of medical care under its program. Even physicians who expressed serious reservations about the proposed program approached the discussions with an objective attitude and were most generous with their advice and suggestions. This certainly is in the best tradition of the medical profession, and of democracy, where free men of good will join together to find ways of meeting human needs. In other areas and in earlier times, the use of ostracism and sanctions against new plans proved not only unedifying but ineffective. This spirit on the part of Michigan Medicine holds promise of a mature and constructive approach, not only to the possible development of new medical care programs, but to the perfection and extension of existing plans.

INTERPOLATION BY LEONARD WOODCOCK: I understand that at this convention you have approved a set of proposals on medical insurance. From accounts in the newspapers, it would appear that you have made real progress and have taken a sound approach to such important matters as affirming the service principle, extending the range of service benefits, and raising the income ceilings and making them work. And I am also happy to hear you have reaffirmed the all-important community-rating principle.

Obviously, we must reserve final assessment of your new program until it is more fully developed. Naturally, too, we shall want to know what it will cost. I can, however, endorse the direction that has been taken.

If we lived in a totalitarian state the kind of problems we have been discussing would be handled by decree. This is not the way we do things in America. While the processes by which we advance in a democracy are infinitely more arduous, our experience has shown that sound and practical solutions to all our problems can be found.

I personally believe that America is, in truth, the last best hope of freedom in this very troubled world of ours. We are blessed, as no other people in the world, with great natural resources, with an extremely efficient economy, with a highly productive agriculture—we are really blessed as no other people in the world are blessed.

But I think we need always to keep in mind—doctor and labor leader, banker, farmer, business man and factory worker—we need always to realize that fundamentally the struggle in the world between the forces of freedom and the forces of tyranny is not a struggle for geography but is essentially a struggle for the hearts and the minds and the loyalties of the people of the world.

And freedom will win that struggle, not by the size and destructive capacity of its H-bomb. We need, because of the necessities and the realities of the world situation, to be strong militarily to meet the threat of Communist aggression, but we must always understand that military power is but the negative aspect of the total struggle against the forces of Communist tyranny. In the long pull, freedom will win only if it can attract to its side hundreds of millions of uncommitted people, and they are going to judge freedom in a large measure by what we in America do with the opportunities that freedom gives us. They are going to judge us, not by our industrial indexes, although they are very impressive; or by the fact that the American economy yielded in excess of four hundred billion dollars in gross national product last year, although that was impressive. They are not going to judge us by the level of our technology or by the speed of our jet planes or the number of new shiny Chevrolets that General Motors turns out on its many assembly lines, although all of these economic facts are very impressive.

They are going to judge us by the true measure of the greatness of any civilization; by the social and moral capacity of the society to translate material values into human values, to reflect technological progress in human progress and human happiness and human dignity.

President's Message

The Challenge

What does this next year hold for us Doctors of Michigan? To specifically prognosticate is impossible, but certain funds, statements and happenings in the past few months allow us to make reasonable assumptions. Recent piecemeal infringement of our basic philosophy of the practice of medicine by third parties alarms me and I feel that as a united profession we must make our stand and fight *for* what we think is right—*right for the people we serve.*

You will note that I said "fight for" and not "fight against," as so often Doctors are berated. We know this criticism is mistaken but we must let all people know we are fighting *for* their free choice of a physician. This must be our basic belief, as it has been down through the centuries. This doctor-patient relationship, voluntarily established by the patient who chooses a physician and by the doctor who assumes responsibility for the patient's care must be maintained. No third party must be allowed to arbitrarily set up restrictions that would alter the basic relationship. These freedoms of patients and doctors are closely allied; take away one and eventually all may be lost.

We must emphasize that we are fighting for this free choice of physician, a "status quo" if you like, for the benefit of the people; of people in all walks of life, and not for the benefit of the Doctor. Actually, the physicians lot might be easier under third party control, whether it be governmental, hospital, or pressure groups. Hours could be shorter, vacations more often, and retirement benefits more secure. However, we know, under previous existing plans of this type, that the caliber of medical care suffered; that the "art of medicine" quickly died out, and that people who could, preferred paying for their private physician in addition to the "Plan's" cost. This free choice is not nebulous or irrelevant. It is something deep and sincere in peoples' hearts and it is something that we all must fight for.

By this time the results of our Market-Opinion Survey on Pre-Paid Health Care have been given to our House of Delegates, and decisions and directions have been given to the Board of Blue Shield and to us Doctors.

With the help and backing of each of you, your Officers and Councillors will see that your mandates are consummated. The horizon may be hazy at this time, but I am confident that we can achieve what we desire.

Geo. W. Slagle.

President Michigan State Medical Society

Editorial

MENTAL HEALTH AND MENTAL ILLNESS

Mental illness has long had a "stigma" attached to it that presents serious obstacles to the treatment and rehabilitation of psychiatric patients. This stigma seems to suggest that the causes of mental illness are shameful, evil and unnatural. In fact, relatives of mentally ill patients often refuse to admit the illness is mental and take the patient to the internist, gynecologist or neurologist or any other doctor, rather than the psychiatrist. And, finally, when it is evident to them that the illness is mental, they rationalize that the mental condition must be caused by a head injury, brain tumor or some other physical cause. It is only recently that people are beginning to break through this stigma and view mental illness in its proper sphere.

As this proper understanding of mental illness by the public becomes more accepted, the more the general practitioner will take his proper role as the first line of defense against mental illness. This is evidenced by the American Psychiatric Association and the American Academy of General Practice, forming a joint committee this past year to stimulate interest in this project. We, in Michigan, must encourage the men in general practice to visit and give help in our mental hospitals, as well as to encourage general hospitals to create psychiatric facilities and wards, within their framework.

Your Mental Health Committee has been in favor of county medical societies creating mental health committees and has offered assistance to county medical societies in developing programs in the field of mental health.

The Committee maintains its deep interest in teen-age crime and juvenile delinquency. It judges that a carefully selected commission of twelve to fifteen members to study the issues involved is probably the best long term approach to the problem.

The Committee strongly endorses the resolution approved by the House of Delegates of the AMA and recorded in the *Journal of the American Medical Association*, Vol. 163, p. 52 (January 5, 1957). This resolution points out that certain types of alcoholic patients should be accepted by general hospitals as medical cases and so treated. Hospital staffs are urged to cooperate in this program.

The articles appearing in this issue may stimulate interest in further communications covering specific areas or topics in the field of Mental Health. The Committee will attempt to answer any such requests emanating from the readers of this JOURNAL. We are grateful to the State Medical Society for the opportunity to participate in this issue of the JOURNAL.

IVAN A. LACORE, M.D., *Chairman*
MENTAL HEALTH COMMITTEE

PRACTICAL CITIZENSHIP

The Michigan Medical Service—Blue Shield—and its program are a direct exposition of the place of the doctor in the eyes of the public and in the work of the public and the state. At the annual meeting of the Michigan State Medical Society in Pontiac in September, 1931, the House of Delegates adopted a resolution authorizing the appointment of a committee to study the costs of medical care. Under this authorization, Carl F. Moll, M.D., of Flint, the president at that time, appointed a study committee consisting of: W. H. Marshall, M.D., Flint, chairman; F. A. Baker, M.D., Pontiac; L. G. Christian, M.D., Lansing; B. U. Esterbrook, M.D., Detroit; C. S. Gorsline, M.D., Battle Creek; and F. C. Warnshuis, M.D., secretary *ex officio*.

The committee organized and developed a study plan. Nathan Sinai, D.P.H., of the University of Michigan, was the director of this study. A survey was made of every item of medical and health expense for a group of approximately 40,000 people in various areas of the state over a period of a year's time. The study of the major committee included a trip to Europe and especially England, an analysis of all the information, publishing of a book in June, 1933, and the outlining of a "Mutual Health Service" which was published in THE JOURNAL in May, 1934* The Mutual Health program suggested by this committee failed of adoption by the House of Delegates, but it

*See footnote on next page.

served as the basis upon which other workers in various parts of the state developed plans and programs, and ultimately Michigan Medical Service evolved. It is interesting to note that of the original committee three are still alive: L. G. Christian of Lansing, C. S. Gorsline of Battle Creek, and Fred A. Baker of Pontiac.

Throughout the years, our State Medical Society officers, many of whom have passed on, devoted time, effort, material and all sorts of resources and personal sacrifice in working out a program to relieve the high and catastrophic costs of medical care. Michigan Medical Service was the result of research and study by these devoted pioneers working in a totally new field of endeavor, apparently far removed from the practice of medicine. In the November issue of THE JOURNAL we will report another effort along a kindred line. During this year the State Medical Society has conducted a mammoth Market Opinion Survey involving almost half a million of our state's citizens, trying to find what they wish in the nature of pre-paid medical care—and if they want it. We have also surveyed the medical profession to determine their desires and their willingness to work. These reports will be presented in the November JOURNAL.

Through the years it has always been the experience that leaders, pioneers, and forward thinkers are ready to work and to devote not only their spare time but their very important business hours, days and weeks which should be devoted to their practice, to planning and organizing. Had it not been for these men, medical societies would have died years ago. During this current year and at the last meeting of the House of Delegates, decisive action has been taken more clearly to define and more distinctly to outline the provisions for care to our patients, and to protect our own vital interests in preservation of the private practice of medicine. This work has been done by many dedicated and conscientious physicians.

*After the publication of the book in June, 1933, Dr. C. S. Gorsline retired from this committee and three others were appointed: Stuart Pritchard, M.D., of Battle Creek, I. W. Green, M.D., of Owosso, and Phil Riley, M.D., of Jackson. The readjusted committee, with Henry Luce, M.D., of Detroit, as Speaker of the House, was responsible for the Mutual Health Service program. Later, Ferris Smith, M.D., of Grand Rapids, and Ralph Pino, M.D., of Detroit, became members of this same study committee, and it was due to Ralph Pino's untiring efforts that the study continued. He was chairman when the final work was being done leading to the establishment of Michigan Medical Service.

The course has been outlined; the final and ultimate result, even more than in the past three decades, must depend upon the cooperation and the effective services given by *all* of our members. It is up to the general membership of the Society now to carry through and see that the plans and obligations are extended and consummated; that the pledges and promises of the Michigan State Medical Society as expressed by our leaders and our House of Delegates are meticulously performed; that the preservation of our dignity and of our laboriously established goodwill through the years is a truly devoted picture; and that there will be no misuses or untoward burdens. Our public is at attention and every member is obligated to carry though as a duty to his patients and his confreres.

FEDERAL LEGISLATION

Congress has now adjourned. The senators and congressmen are at home and available for conversation and contacts; in fact, they are anxious to make these contacts with their constituents. There are some things the medical profession is especially interested in which could be discussed with them, or letters could be written to them. Of utmost importance is the Jenkins-Keogh bill. Bills of this nature have been in the Congress for over ten years without much progress, but now for the first time a hearing has been announced to start on January 7, 1958. All of our members probably know what the Jenkins-Keogh plan is. It is a program to allow self-employed professional persons to set aside a portion of their income in pension plans and defer income tax payments until those plans materialize in later years as endowments or pensions. At that time they will be taxed according to the prevailing tax.

The plan is one of simple justice. All industrially employed and most salaried persons are in position to take advantage of this reduction in tax now through laws that have been in effect for years, whereby the employer can invest money, which he otherwise would be paying as salary to his employee, in income-producing securities designated to be paid after retirement age in the nature of a pension. Tremendous amounts are being saved now for our friends and many of our neighbors who are in industrial employment. There is no reason professional persons should not be granted the same privilege. Letters to your friends in Congress do sometimes produce results.

THE CROSSROADS

The House of Delegates at the Annual Session, September 23 and 24, 1957, decided the future of the Blue Shield in Michigan. Our subscribers have indicated their desire for extensions of the service contracts. Management of Michigan Medical Service has developed a series of contracts offering the various types of care on full payment, deductible, or coinsurance basis, as the individual group may require.

These services can all, or each separately, be given successfully, if and when the doctors of Michigan decide they are willing and ready to render the care and to recognize the contract provisions. Such must be done or no group medical care program can succeed. Approximately half of the service contracts are to be renewed within a few months. Labor has protested: (1) the overutilization and misutilization leading to extra costs and increased rates, (2) has announced its goal of government medicine, and (3) has organized a "Community Health Association" prepared and ready to issue medical service contracts if and when their leaders or they themselves may decide.

The Michigan State Medical Society in an utterly new field put our Blue Shield plan in operation with over seventy thousand subscribers in a very few months. Our doctors must realize that can be done again—the way has been shown.

Remember Michigan Medical Service is not a rich "insurance" company. It is ourselves, an integral part of the Michigan State Medical Society. No matter what any group may be induced to demand, the future of prepaid medicine is now in the balance. The decision must be made correctly *if independent practice is to prevail.*

Think it over, doctor—the vote of your delegate in September must be proven correct or it could be a vote to submit to control by pressure groups at home or politicians in Washington.

WHAT DO YOU MEAN—"NON-PROFIT"?

One of the chief distinctions between medically sponsored prepayment plans—such as Blue Shield—and the commercial health and accident insurance companies, is that Blue Shield is conducted on a "nonprofit" basis, whereas the insurance companies are frankly business enterprises operated to earn a profit for their owners.

To state this difference is not to imply any criticism of either. The insurance companies have a long and honorable history of public service and they are an important part of America's business community.

Blue Shield, on the other hand, serves largely as an agency of the medical profession, performing a community service. Initiated by the medical profession, with the help of local industry, labor and civic leaders, Blue Shield is designed for one purpose only: to help people pay for medical services whenever the need for such services arises.

Blue Shield has succeeded in pioneering the medical care prepayment movement because the profession has guided it and supported it. Blue Shield's working capital was the pledge of the participating physician to deliver the medical services that Blue Shield has promised on his behalf.

In some cases, the participating physicians have accepted a fraction of scheduled Blue Shield payments in order to tide an infant plan over its early trials. In every case, local professional leaders have given their local Blue Shield Plans incalculable hours of service as trustees and advisers. None has ever accepted one penny of compensation for such service as a committee member or trustee. As an agency of the medical profession, created for the sole purpose of facilitating the doctor's job of service to his patients, there has never been any need (for any third party) to make a profit out of the Blue Shield transaction.

Blue Shield's success is measured by the proportion of its income dollar that is expended for services to subscribers, the smallness of its operating costs and the quality of its doctor-support—*not* by the size of its reserves or its net earnings.

These earnings—these profits, if you will—belong to the subscriber.

"Nonprofit" does not mean *no* profit. Much less does "nonprofit" mean a profit-less operation. "Nonprofit" in Blue Shield means that the earnings of the Plan belong to the subscribers who support the Plan.

The symptom-complex which is officially designated as pernicious anemia may, in many of its features also betray malignancy of the stomach, and particularly of the right colon sector.

* * *

A neoplasm may attain a considerable size without causing serious obstruction of the right colon.

NO KNOWN CONTRAINDICATIONS

ROLICTON®

permits high dosage, more effective diuresis in more patients

The low incidence of side action with Rolicton (brand of amisometradine) permits high dosage, extending the range of effective diuresis to a greater number of patients than was previously possible.

Laboratory studies demonstrate that Searle's new oral diuretic, Rolicton, causes positive diuresis with an essentially balanced excretion of water, sodium and chlorides.

Settel[1] studied the effect of Rolicton in forty-seven patients and found no serious side effects. Assali, who observed the action of Rolicton in five patients with severe toxemia of pregnancy, states[2] that side actions are essentially nonexistent. Side actions of such low incidence, together with its diuretic efficacy, suggest a high order of usefulness for Rolicton.

One tablet of Rolicton, b.i.d., is usually adequate to maintain patients free of edema after the first day's dosage of four tablets. Some patients respond well to one tablet daily. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

Normal glomerulus, showing arteriole musculature, glomerular epithelial podocytes, and "epitheloid" muscle cells of vas efferens.

1. Settel, E.: Rolicton® (Aminoisometradine), a New, Nonmercurial Diuretic, Postgrad. Med. *21*:186 (Feb.) 1957.
2. Assali, N. S.: Personal communication, May 28, 1956.

SEARLE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

ASIAN STRAIN INFLUENZA

There are four main types of influenza viruses titled A, B, C, and D. Within each type, various new strains develop from time to time. Currently, we have a new strain that has developed within type A. This new strain or variant of type A influenza virus was first identified from a case of influenza that was part of an outbreak of the disease in Asia. As a result it was designated as the Asian or Far East strain. Public fancy immediately labeled influenza resulting from this variant of type A influenza virus as "Asiatic Flu." This is unfortunate, because it gives the public the impression that they are faced with an invasion of a rare exotic type of disease. That which is more unfortunate is that it carries with it the fear of the unknown. It would have been better had the new strain been called just another variant of type A influenza virus, which is actually all that it is.

This new strain of type A influenza virus has certain characteristics that help to remove fear once the truth concerning it is known. It causes a relatively mild disease, has few complications, and results in almost no fatalities.

Symptoms.—One of the characteristics of any "touch of the flu" is that its onset is abrupt with few or no premonitory symptoms. The time lapse from exposure to illness among susceptibles is frequently less than twenty-four hours. The fact that a group of people working or living together in close quarters become ill at the same time seems to breed hysteria away beyond the importance of the affliction. The symptoms can be any or all of the following: fever, chills, headache, sore throat, cough, and soreness in the back and limbs. Although the temperature may reach 102 to 103° F., the illness is short-lived and lasts only two to three days. However, it leaves the patient exhausted and feeling that he has gone through an illness of long duration.

Treatment.—No medicine as yet known will cure influenza. The antibiotics are useless and could be harmful, and should be used only if complications, such as pneumonia, appear imminent. The only thing to do is to go to bed and let nature work for you. Another advantage of bed rest is that the patient is not circulating and spreading the virus. By the same token a person with the "flu," Asiatic, Far Eastern or otherwise, should not have visitors—solely for his own good, since visitors bring in bacterial contaminants that can result in serious secondary infections for a person already ill from influenza.

Precautions.—When influenza of any type is prevalent in a community, the air is so laden with flu viruses that it is impossible to avoid getting into the path of coughs and sneezes of those already infected but not yet "sick enough" to go to bed.

There are, however, a few precautions that can be taken. One can avoid a maximum exposure by avoiding crowds, insofar as possible. Proper rest and proper food are of major importance in overcoming bacterial invaders that are actually the cause of mortality in influenza.

Prevention.—The influenza vaccine we now have is not of any value in preventing so-called Asian or Far East influenza, since it does not contain any substances that will result in the development of antibodies against this new variant of influenza virus type A.

It does, however, appear likely that a vaccine designed specifically to combat this variant will be available at some later date. This vaccine, when available, will offer about 70 per cent protection. It is probable that the supply will be llmited. However, there are no indications at this time that this new strain of influenza virus type A has any of the deadly characteristics of the influenza virus that was so devastating during 1918-1919.

Sensible, sane, sanitary living should suffice. Certainly, there is no reason for panic.

POLIO NOTE

Of the 235 cases of poliomyelitis reported this year, only forty-five are paralytic and the remaining 190, are reported as nonparalytic. Normally paralytic and nonparalytic are about 50-50.

NEW LOCAL HEALTH DIRECTORS

John S. Wisely, M.D., became Director of the Lenawee County Health Department on August 1.

Earl Hasty, M.D., was appointed Director of District Health Department No. 2 as of July 1.

Dorothy V. DuVall, M.D., was named Director of the Chippewa-Luce-Mackinac Health Department, effective August 2.

A. B. Mitchell, M.D., formerly Director of the Allegan County Health Department, became Director of the combined Shiawassee-Livingston District Health Department on August 1. The Shiawassee County office is in the Courthouse at Corunna and the Livingston office is in the Courthouse Annex in Howell.

More babies are being born in hospitals and with a doctor in attendance than ever before, Health Information Foundation reports. In 1935, only 37 per cent were born in hospitals and 13 per cent of all births were unattended by doctors. In 1956, almost 95 per cent were hospital-born, and doctors attended 97 per cent of all births.

In Memoriam

Ray S. Morrish, M.D., Flint physician and surgeon and prominent civic leader, died August 13, 1957, at the age of sixty-nine.

Doctor Morrish was president of the Michigan State Medical Society in 1945 and was a former secretary and president of Genesee County Medical Society. He was also active in numerous medical groups and was a former president of the Flint Academy of Surgery.

Dr. Morrish's grandparents came to Michigan from England in 1850 and settled in Flint Township. The family had a farm which is now part of Bishop Airport. He received his doctor of medicine degree from the University of Michigan in 1912.

During World War I, he entered the Army Medical Corps as a lieutenant. He served a month at Ann Arbor, then became assistant commander at the Base Hospital at Camp Shelby, Mississippi, where he rose to the rank of major.

Returning to Flint, he began a series of postgraduate studies in surgery, tuberculosis, traumatic surgery and tumors and malignancies.

He taught residents and interns at Hurley Hospital from 1931 to 1940 and also classes at Wayne State University and the University of Michigan. He was director of general surgery at Hurley from 1931 to 1940.

Dr. Morrish limited his practice to surgery. He was on the staffs of Hurley Hospital and St. Joseph Hospital and was acting assistant surgeon for the Veterans Administration from 1919 to 1938.

Serving on the board of directors of the Genesee Red Cross Chapter from 1924 to 1951, Dr. Morrish was its chairman from 1939 to 1946. He was also chairman of a fourteen-county Red Cross regional co-ordinating committee.

Dr. Morrish was a fellow of the International College of Surgeons and was certified as a specialist in general surgery by the International Board of Surgery.

Aura Andrews Hoyt, M.D., of Battle Creek, for twenty-four years health officer of the community, died August 8, 1957, at the age of seventy-seven.

Dr. Hoyt graduated in medicine at the University of Michigan and, after his internship in New York City, practiced in the west for one year before returning to Battle Creek.

After his retirement as health officer in July, 1944, Dr. Hoyt entered private practice and continued as director of public clinics conducted by the health department.

Charles W. Heald, M.D., Battle Creek physician, died of a heart ailment August 6, 1957, at the age of eighty-one.

Before entering the medical profession, Dr. Heald attended the Battle Creek College and afterward engaged in religious work for the Seventh-Day Adventist Church, serving in various communities as assistant to pastors. He later attended the American Medical Missionary College of Medicine, graduating in 1906.

Dr. Heald was born in Fairfield, Iowa, July 7, 1876.

Alvin J. Swingle, M.D., Benton Harbor physician and surgeon, died August 1, 1957, of a heart attack. He was forty-six years old.

Born September 15, 1911, Dr. Swingle graduated from Ohio State University Medical School in 1937 and began his practice of medicine in Mandan, N. D. Upon entering the U. S. Medical Corps, World War II, he rose to the rank of lieutenant colonel and was a member of a surgical team in the European theater.

After the war, Dr. Swingle taught surgery at Marquette University, before coming to Benton Harbor in 1949.

Dr. Swingle was active in civic and fraternal affairs. He was a member of Lake Shore Lodge 298, the Masons; the DeWitt Clinton Consistory, Commander of the Saladin Temple. He was a member of the Kiwanis Club and active member of Saron Lutheran Church, St. Joseph.

Frederick G. Novy, M.D., Ann Arbor, died August 8, 1957, at the age of ninety-two.

Born in Chicago, Frederick Novy received his early schooling there. He served on the University of Michigan faculty for forty-nine years, heading its bacteriology laboratory from 1902 until his retirement in 1935. His last two years of active service were as dean of the medical school.

In 1891, he established the first credit course in bacteriology in any American university.

Dr. Novy brought to the new laboratory his training in Germany and France under Louis Pasteur and Robert Koch, and a demand for strict attention to scientific procedure. He discovered and named many micro-organisms, among them Novyi, which causes relapsing fever. He developed antisteptics and in 1903 introduced new methods for cultivation of blood parasites—methods still used today.

Dr. Novy was a pioneer in the study of allergies and laid the groundwork for modern antihistamines. Much laboratory apparatus he invented still bears his name.

All three of his sons are doctors of medicine and his two daughters are married to physicians: Robert L. of Detroit; Frank O. of Saginaw; Frederick G. of Berkeley, California; Mrs. Warren C. Lambert of Marquette and Mrs. Archibald Diack of Portland, Oregon.

NEWS MEDICAL

MEDICAL AUTHORS

Jack Kevorkian, M.D., Pontiac, is the author of an article entitled "Rapid and Accurate Ophthalmoscopic Determination of Circulatory Arrest," published in the *Journal of the American Medical Association,* August 10, 1957.

William D. Robinson, M.D., Ann Arbor, is the author of an article entitled "Current Status of the Treatment of Gout," published in the *Journal of the American Medical Association,* August 10, 1957.

J. Reimer Wolter, M.D., Ann Arbor, is the author of an article entitled "Innervation of the Corneal Endothelium of the Eye of a Rabbit," published in AMA *Archives of Ophthalmology,* August, 1957.

Klaus Hergt, M.D., and **John L. Langin, M.D.,** Bay City, are the authors of an article entitled "Serum Transaminase Determination," published in the *Journal of the Medical Sciences,* January, 1957.

Albert D. Reudemann, Jr., M.D., Detroit, is the author of an article entitled "Automobile Safety Device—Headrest to Prevent Whiplash Injury," published in the *Journal of the American Medical Association,* August 24, 1957.

W. D. Robinson, M.D., of Ann Arbor, is author of a special report, "Current Status of the Treatment of Scalps," which appeared in JAMA of August 10, 1957.

A. D. Ruedemann, Jr., M.D., of Detroit, is the author of an interesting article under "Clinical Notes" in *The Journal of the American Medical Association,* August 24, 1957. The subject of the note is "Automobile Safety Device—Headrest to Prevent Whiplash Injury."

J. R. Simpson, M.D., et-al, authored an original article, "Serum Lactic Dehydrogenase—a Diagnostic Aid in Myocardial Infarction" which appeared in JAMA of September 7, 1957.

Vance Fentress, M.D., and **D. J. Sandweiss, M.D.,** of Detroit, are authors of an original article, "Segal's Tubeless Gastric Analysis with Azure, a Resin Compound," which appeared in JAMA of September 7, 1957.

* * *

Seminar on Chronically Ill.—The State of Michigan Office of Hospital Survey and Construction called and sponsored a three-day meeting, a seminar on the chronically ill, at Haven Hill Lodge on May 26, 1957. The opening meeting on Sunday evening, May 26, featured a talk and a discussion on Michigan's changing health picture led by Vlado Getting, M.D., of the University of Michigan School of Public Health. This was a discussion of the health picture which is changing from one of acute illness to one of chronic illness within local communities; and hospitalization and medical care in the future is going to have to be aimed along these lines more than it has been in the past. Dr. S. J. Axelrod from the University of Michigan Department of Public Health reported on his survey of medical facilities in Michigan, which had been primarily devoted to the Ingham County area, in which a rather detailed study had been made. It was a report of available services, recommendations to be made later. There were some inaccuracies noted in relations to numbers and types of units, but, in general, it was a most informative report.

The rest of Monday was devoted to discussions in groups in relation to the problems of community care for the chronically ill. The group was broken into four separate study groups, which discussed the problems in general, each bringing in their report; in the evening, these reports were all consolidated into three main phases: (1) improved methods of care, (2) improved methods of economics, and (3) prevention of and education for chronic disease. The recommendation of most interest to the medical profession was the urging that medical personnel accept more responsibility regarding the problems of chronic illness and the long term patient within the community, and that this be considered not only an individual patient problem but also an interesting community problem.

In the groups, most of the discussion centered upon methods of improved care, finances including prepaid insurance, and prevention or education to prevent chronic illness. It was suggested that the community should recognize that the chronically ill or handicapped represent an honorable state and not one to be frowned upon, and that the number of such individuals in the hospitals is a reflection on the moral, physical, social, emotional and economic environment of the community. The problem of assimilating the chronically ill as part of the community is an interesting problem, and the answer is not necessarily in brick and mortar and hospital beds, but in a better organized community approach to the problem and better use of home care. Discussions revolved around the doctors' offices or clinics, general hospital care, the chronic disease hospital, nursing homes, and home care. The final recommendation was for the development of (1) a pilot program to cover all of the aspects of the community in relation to the problems of the chronically ill, and (2) a pilot or trial program for further development and experimentation in relation to prepaid insurance.

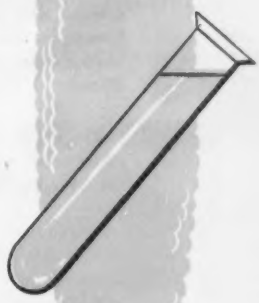
* * *

The International College of Surgeons has announced two European congresses. One met in Vienna, October

(Continued on Page 1310)

CORN OIL is a Prime Source of UNsaturated Fatty Acid

Numerous clinical studies emphasize its efficacy in the reduction and control of serum cholesterol levels



Physicians are quite aware of the rapidly growing appreciation of the role of dietary lipids in health and disease. Accumulating metabolic studies throughout the world indicate that serum cholesterol levels may be influenced more by the *kind* than by the *amount* of the dietary fat.

Unsaturated fats tend to depress serum cholesterol levels in many patients, whereas saturated fats may have the opposite effect. Medical references on this subject, as well as other findings concerning unsaturated fatty acids in nutrition, may be found in the book, "Vegetable Oils in Nutrition."

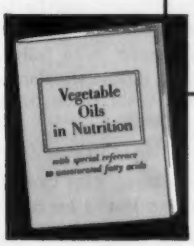
Mazola Corn Oil is an excellent source of *un*saturated fatty acids... 85% of its component fatty acids are unsaturated... average values being 55% linoleic acid, 30% oleic acid. Mazola is unadulterated corn oil in its natural form... *not* flavored, *not* blended, *not* hydrogenated. Well tolerated, easily digested, readily absorbed, Mazola is also an excellent carrier for fat soluble vitamins.

Mazola Corn Oil is widely used for salad dressings, in frying, cooking and baking... and thus may be included palatably in great variety as a replacement for part of the daily fat intake.

COMPARATIVE COMPOSITIONS OF FOOD FATS AND OILS

Fatty Acids as Percentage of Total Acids

Fat	Saturated Ave.	Saturated Range	Oleic Ave.	Oleic Range	Linoleic Ave.	Linoleic Range	Linolenic Ave.	Linolenic Range	Arachidonic Ave.	Iodine Value Average	Iodine Value Range
Butter	—	46-48	—	—	4.0	—	1.2	—	0.2	—	26-42
Coconut oil	—	75-88	—	5-8	—	1.0-2.5	—	—	—	—	7-10
Corn oil	13	11-15	—	23-40	56	46-66	—	0.0-0.6	—	126	113-131
Cottonseed oil	26	21-30	27	22-36	47	34-57	—	—	—	105	90-117
Lard	43	—	46	—	10	15.6	0.5	—	0.5 (2.1)	—	53-77
Linseed oil	—	6-12	—	13-31	—	10-27	—	30-64	—	—	170-204
Margarine	23	15-23	62	59-77	5.8	5-11	—	0.1-0.9	0	81	74-85
Olive oil	—	8-16	—	53-86	—	4-20	—	—	—	—	80-88
Peanut oil	17	14-22	54	44-65	29	20-37	—	—	—	98	90-102
Shortening	25	17-45	62	43-79	5	3-12	—	0.2-0.6	0-0.5	78	59-80
Soybean oil	15	11-18	25	18-58	55	28-62	5.1	0.3-10	—	130	100-143
Tallow (beef)	53	—	42	—	4	5.3	0.5	—	0.5	—	40-48



Iodine numbers are an accepted measure of the degree of unsaturation of vegetable oils.

TO PHYSICIANS interested in the study and management of high cholesterol blood levels, this most recent monograph will provide helpful information. It is free on request. Write to: Corn Products Refining Company, 17 Battery Place, New York 4, N. Y.

CORN PRODUCTS REFINING COMPANY
17 Battery Place,
New York 4, N. Y.

(Continued from Page 1308)

18-20, 1957, and the other will convene in conjunction with the World's Fair in Brussels, May 15-18, 1958. The Vienna Conference was under the auspices of the Vienna section of the International College of Surgeons, and under the direction of Dr. Felix Mandl and Professor Leopold Schonbauer, both of the surgical department of the University of Vienna. The meeting brought together the German, Austrian, Dutch, Swiss, and other sections. About seventy-five papers were presented. The sessions were held in the Billroth-Haus in Vienna. Information about the May meeting is available at the headquarters' office, 1516 Lakeshore Drive, Chicago 10, Illinois.

* * *

The doctor draft law went out of existence on June 30 after nearly seven years on the federal books. Figures collected by the selective service headquarters show that forty-five priority 1 and priority 2 physicians and twenty-seven dentists remain in the 1-A pool, and 337 physicians and 101 dentists in the same priorities, were deferred for vocational essentiality, and 1,768 physicians and 555 dentists in priorities 1 and 2 hold deferrment as 4-F's.

* * *

Poliomyelitis Literature.—The National Foundation for Infantile Paralysis maintains a listing of all articles on poliomyelitis published in the United States and abroad, and publishes it monthly. The June listing just received, contains 104 titles, of which Michigan furnished two: "Mechanisms of Persistent and Masked Infections in Tissue Culture," *Annuals New York Medical Society,* April, 1957, by W. W. Ackerman, University of Michigan Virus Laboratory, Ann Arbor, and "The Nature of the Formalin Inactivation of Poliomyelitis Virus," *Journal Immunology,* June, 1956, by E. A. Timm, I. W. McLean, Jr., C. H. Kupsky, and A. E. Hook, Parke-Davis, Detroit.

* * *

The August number of the Blue Shield Medical Care Plans Newsletter devoted almost two pages to quotations from THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY for June. It quoted extensively from the articles by L. Fernald Foster, M.D., President of Michigan Medical Service, George W. Slagle, M. D., President-Elect of the Michigan State Medical Society, and J. C. Ketchum, Executive Vice President of the Plan. In closing the article, the editor remarks: "Each year when the Blue Shield issue of *Michigan Medical Journal* appears, it stands as one of the outstanding examples of productive professional relations. The same kind of annual Blue Shield edition could well be made a part of every state medical publication so that all doctors, everywhere, might understand more fully and completely the role of physicians in further developments essential to the continuation of voluntary health care coverage under the leadership of physicians."

* * *

Top Trophy to Michigan.—Michigan Blue Cross-Blue Shield was named winner of the top trophy for its 1956-

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57 public relations program at the annual Blue Cross-Blue Shield Public Relations Institute held at the University of Wisconsin, August 15, 1957. The Michigan Blue Cross-Blue Shield entry, one of fifty submitted by the eighty-six Plans in the United States, Canada and Puerto Rico, was selected Grand Winner in the overall judging on the basis of its "systematic realization of planned objectives." Louis Graff, Director of Public Relations and Advertising of Michigan Blue Cross-Blue Shield, accepted the award at the Annual Award Dinner.

In accepting the award, Graff said: "Few institutions conceived in the public interest, as is Blue Cross, have a greater moral challenge to bridge the gap between health problems, which are apparent to everyone, and financial solutions which are exceedingly complex, often obscure." . . . "Our basic task in communications," he added, "is to convince the public that we understand the emotional and economic worry associated with human illness. And more than that, to demonstrate through our combined creative restlessness that we in Blue Cross are still pioneers in finding solutions to these problems." . . . "Inescapably," Graff concluded, "our public relations task tie us to the welfare of the community and to the well-being of the individual."

Those judging the entries were: Harry E. Clark, *Family Week Magazine;* Alton D. Farber, J. Walter Company; and, Robert Cunningham, Editor, *Modern Hospital.*

* * *

The National Disease and Therapeutic Index, a research project of Taylor, Harkins and Lea, Inc., Philadelphia, has published its first report in July, 1957, a mimeographed copy of twenty-one pages. This report covers neoplasms as seen by practicing physicians. This survey is a unique research project designed in the hope of providing a continuous flow of reliable basic facts on medical practice in the United States. Each of the panel of more than eight hundred participating physicians reports on all private patient visits during a forty-eight-hour-period, once each quarter. Approved statisticians then take the information and analyze it. The study was sponsored and supported by four leading ethical pharmaceutical manufacturers: Ciba, Eli Lilly, Smith, Kline and French, and the Upjohn Company. The study started in February, 1956, and from February 1 through December 31, they collected information on a total of 91,801, patient visits. Of this 91,801, 2,536, or 2.8 per cent, were recorded with diagnosis of neoplasm. 35.2 per cent were benign neoplasms, 9.1 per cent were neoplasms of unspecified nature, 1.5 per cent were malignant neoplasms of the buccal cavity and pharynx, 10.2 per cent were malignant neoplasms of digestive organs and the peritonium, 4.7 per cent were malignant neoplasms of the respiratory system, 19 per cent were malignant neoplasms of breast and genito-urinary organs, 12.1 per cent malignant neoplasms of other and unspecified sites, 8.2 per cent were malignant neoplasms of lymphatic and hematophytic tissue.

(Continued on Page 1314)

For—
quick symptomatic relief
or prophylaxis in
urinary tract infections

NEW

SUROMATE

TRADEMARK

patch

THE TRIPLE SULFA

Sulfadiazine	100 mg.
Sulfamerazine	100 mg.
Sulfacetamide	100 mg.

An *improved* combination including sulfacetamide . . . efficient antibacterial of exceptional solubility.[1] Offers wide-spectrum activity with low dosage, minimal danger of crystalluria or sensitization.[2] Preferred to antibiotics because drug resistance or superinfection is less likely.[3]

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+ Ext. Hyoscyamus (alkaloids 0.155%) .	5.75 mg.
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Antispasmodic action of hyoscyamus quickly relieves pain, irritation, burning, urgency.[4]

Alkalizing and diuretic effects of potassium citrate enhance sulfonamide solubility and safety.[4]

Supplied: Bottles of 100 tablets.

1. Kerley, L., and Headlee, C. P.: J. Am. Pharm. A. (Scient. Ed.) 45:82, 1956. 2. Lehr, D.: Special Exhibit, Mod. Med. 23:111, No. 2, 1955. 3. Editorial, J.A.M.A. 160:210, 1956. 4. Bastedo, W. A.: Materia Medica, Pharmacology, Therapeutics and Prescription Writing, ed. 4, Philadelphia, W. B. Saunders Company, 1937, pp. 514, 101.

1888

patch

THE E. L. PATCH COMPANY
STONEHAM, MASSACHUSETTS

(Continued from Page 1312)

Peripheral Vascular Disease.—A 16-millimeter film in color with sound has been prepared showing the widespread occurrence of peripheral arterial and venous circulatory disease. A recent survey shows more than 4,808,000 known cases in the United States alone. More than a million new cases arise every three years, of which from 50 to 65 per cent are considered more or less permanent and requiring periodic or continuous treatment. The film runs thirty-two minutes. Arrangements for showing the film can be made by writing to Medical Film Guild, Ltd., 506 West 57th St., New York 19, or Arlington Funk Laboratories, 250 E. 43rd St., New York 17. Please advise if you have available the necessary projection equipment, and at least thirty days' notice should be given.

* * *

Influenza 1957.—In co-operation with the United States Public Health Service, Wyeth Laboratories has produced a book with twenty-nine mimeographed pages giving the complete story of the Asiatic Flu, discussing diagnosis, testing, prevention, and treatment of the disease. One hundred and fifty thousand copies of the booklet are being distributed to the medical profession. It may be had upon request to Joseph E. Dooley, Public Relations, Louis N. Gilman, Inc., 1528 Walnut St., Philadelphia 2, Pennsylvania. This book contains a very interesting history of influenza, known in ancient times, which has produced many pandemics, the most famous one being in 1918 which took 20,000,000 lives.

* * *

Liaison Committee with University of Michigan.—The Michigan State Medical Society has a liaison committee with the University of Michigan, consisting of Bradley Harris, M.D., chairman; F. E. Ludeig, M.D., R. B. Nelson, M.D., and G. C. Wilson, M.D., constituting a Subcommittee on the University Hospital. The Committee has presented problems of the young doctor entering practice to the internes and residents. The presentation was based on the following summation, especially covering the philosophy of the University Hospital and the referring physician:

UNIVERSITY HOSPITAL AND THE LOCAL REFERRING PRACTITIONER

A. Introduction
B. Reasons for patient referrals
   1. The attempt of the local practitioner to get better and more complete medical care for his patient.
   2. To help provide medical material for study for the medical school, interns and residents.
   3. Many times the local practitioner desires re-evaluation of chronic illness, hoping that there may be something new for his patient.
   4. To provide more complete surgical treatment for his patient when such treatment is not available in his community.
   5. Out-patient consultation, such as N.P.I., neurology, tuberculosis, allergy, blood diseases, etc.
   6. Many times the local practitioner desires more adequate treatment regimes that he may continue at home.

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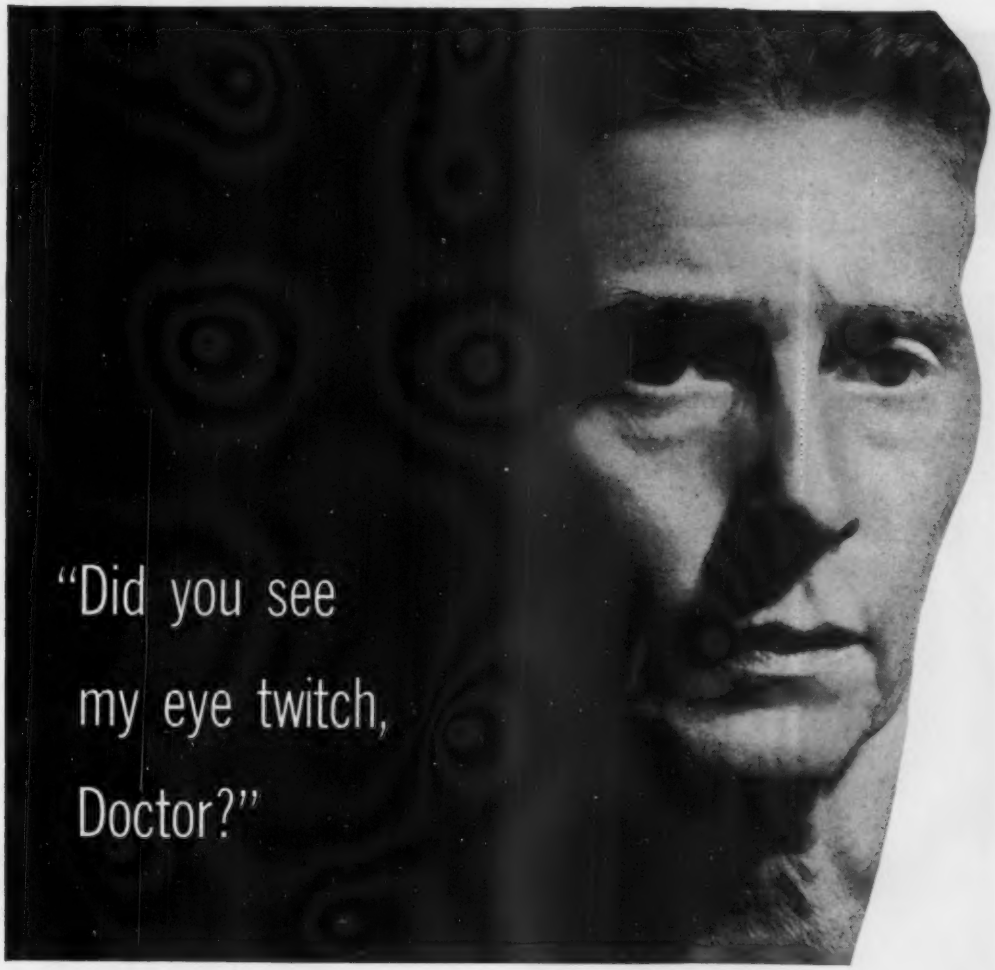

She's nervous—and depressed at the same time: "I just can't get interested in anything."

You feel that a "tranquilizer" will probably relieve her nervousness—but not her depression. On the other hand, stimulants will relieve the depression—but may magnify her nervousness.

In this type of patient, a clinical trial with Dexamyl* often produces gratifying results. 'Dexamyl', a "normalizing" agent, relieves both anxiety and depression and imparts to your patient a sense of cheerfulness, optimism and assurance. A combination of Dexedrine* (dextro-amphetamine sulfate, S.K.F.) and amobarbital, 'Dexamyl' is available as tablets, elixir and Spansule* sustained release capsules (two strengths).
Made only by Smith, Kline & French Laboratories, Philadelphia.

*T.M. Reg. U.S. Pat. Off.

(Continued from Page 1314)

7. Many referrals come to University Hospital because certain counties direct patients to the hospital on the order of the Director of the Poor, by a supervisor, where no doctor may have seen the case. In such instances, there has been no local practitioner.
8. Some referrals are made to the University Hospital because the local practitioner wishes to rid himself of a nuisance patient.
9. Doctors of Osteopathy refer many patients to University Hospital.
   (a) Twenty per cent of medical care in the State of Michigan is now given by D.O.'s. This means that the D.O. is replacing the general practitioner in many areas throughout the State of Michigan.
   (b) For your information, there are approximately 1,800 practicing D.O.'s in the State of Michigan, as compared to around 8,000 M.D.'s. At this time, there are 260 Michigan residents now taking courses in Osteopathic schools. As an example, the County of Oakland has 180 practicing Doctors of Osteopathy. All of these refer patients to University Hospital.

C. Resident and Intern relations with the patient
1. Remember that most patients have complete faith in their local practitioners.
2. Use care while speaking in front of the patient about the treatment he has received from his local practitioner. While the treatment may not have been that you would have used yourself, it should not be mentioned as inadvisable treatment in front of the patient.
3. Careless words can cause dissatisfaction of the patient with his local practitioner and even instigate a malpractice suit against the local practitioner.

D. How to help the local practitioner.
1. Get out reports as promptly as possible.
2. In case of sudden death or serious complications, contact the local practitioner by phone or telegraph.
3. Be sure patient is properly instructed as to the treatments and medications that he must continue. If the patient is given this information, have him contact the local practitioner as soon as possible after his discharge, so that he may take over.
4. Many children have reports sent only to the Crippled Children's Commission, so that just writing a letter is not sufficient; giving the information to the patient or the patient's family is most important.
5. Particular care must be made with children with diabetes and allergies and other serious illnesses. Otherwise, it may be a month before the report gets to the local practitioner.
6. Remember that in two or three years, you will be the local practitioner.

* * *

Asian influenza vaccine is being put on the market and should be in plentiful quantities by cold weather. The AMA Board of Trustees have appointed a committee on influenza to implement the international and operational phases of the AMA program. This committee is the present committee on National Civil Defense which consistes of Harold C. Lueth, M.D.; Cortis F. Enloe, Jr., M.D.; Henry Poer, M.D.; Max L. Lichter, M.D., Detroit; Roscoe L. Sensenich, M.D.;

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and Claude W. Steele, M.D., to whom have been added two members of the board: Hugh H. Hussey, Jr., M.D., and James E. Apple. This committee is busy at work. They have recommended that emergency medical service committees of each state medical society be qualified to cope with the special influenza problem.

* * *

Tuberculosis appears to be on the increase among elementary school age children. Despite a 16 per cent drop in active and probably active tuberculosis cases reported for the state as a whole, the number of children under age ten found to have active or probably active tuberculosis rose 10 per cent in 1956 over the figure for 1952, when this breakdown in tuberculosis cases was first made. The greatest increase occurred among children aged five through nine.

In 1952, the Michigan Department of Health reported a total of 4,066 active and probably active tuberculosis cases, of which 329 were children under ten. In 1956 there were 3,402 active and probably active tuberculosis cases, including 362 children under ten. These figures may reflect the rise in birth rate which followed World War II. They also suggest that the sources of tuberculosis infection for children are not being reduced significantly.

* * *

The Medical Economics publication, beginning September, 1957, is issuing a new volume for young doctors preparing to practice medicine—internes, house physicians, residents, and senior medical students. About thirty-five thousand of them are now receiving the new edition prepared especially for them. Much of the material in the regular *Medical Economics* publication will be used, plus a special lead article, entitled "What Practice Set-up Will Suit You Best." This will use charts, tables, and occupy about twenty pages of text. There was also an article about down to earth advice on the relative merits of solo practice, expense sharing, partnerships, group practice, and salaried work. Special articles will appear each month and will take up the particular problems in the young doctor's horizon, how to find a location, how to get a hospital connection, how to set up an office, how to establish fees, et cetera. We believe this will be a very acceptable addition to the young graduate's training.

* * *

The American College of Physicians has arranged for eight postgraduate courses beginning in October. These are open to members and nonmembers at various fees. The first course lasted five and one-half days, October 7-12, 1957, at the University of Pittsburg, Pittsburg, Pennsylvania. The second course was from October 14-18, 1957, at the Medical College of Virginia, Richmond, Virginia. The third, on October 21-25, 1957, was held at the University of Wisconsin Medical School, Madison, Wisconsin. The fourth, October 28 to Novem-

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ber 1, 1957, will be held at Tufts University School of Medicine at Boston, Massachusetts. The fifth, November 1 to 3, 1957, will be at the University of Pennsylvania Graduate School of Medicine, Philadelphia General Hospital, Philadelphia, Pennsylvania. The next, November 18-22, 1957, will be at the National Institutes of Health at Bethesda, Maryland. The seventh, February 10-14, 1958, is scheduled at Duke University School of Medicine, Durham, North Carolina, and the eighth, February 17-21, 1958, at the University of South California School of Medicine, Los Angeles, California. The work at these various schools will be various basic subjects and a complete program may be secured from E. R. Loveland, Executive Secretary, 4200 Pine Street, Philadelphia, Pennsylvania.

* * *

The Ophthalmology Scholarship Fund of the Guild of Prescription Opticians of America, Inc., has announced five additional young physicians who are just beginning their residence training in Ophthalmology. This is a three-year course and the fellowship will amount to $1,800, paid monthly, over the three years of residency. None of these new fellows is from Michigan; one is from Erie, Pennsylvania, one from Nova Scotia, one from Ontario, one from Georgia, and one from Florida. This brings to eleven the number of recipients. Next year's awards will bring it up to the total of eighteen fellowships which the Guild expects to continue in operation, new ones being appointed as old ones finish their course.

* * *

Management of Mass Casualties.—The army has announced that special courses for the management of mass casualties are to be conducted during the fiscal year of 1958. The following dates have been selected: September 9-14, 1957; December 2-7, 1957; March 24-29, 1958; and May 12-17, 1958. The AMA Council on National Defense has allotted a quota of two representatives for each course. Those interested in attending the courses should write directly to the Council on National Defense, American Medical Association, 535 N. Dearborn St., Chicago, advising which course is desired. Since there is limited space, they will be handled on a "first come—first served" basis.

* * *

Dr. James Maxwell, Professor of Otolaryngology of the University of Michigan is again giving a course of lectures at the Graduate School of Medicine of the University of Florida, January 27 to February 1, 1958, midwinter session, Miami Beach, Florida.

* * *

The 22nd Annual Convention of the American College of Gastroenterology was held at The Somerset, Boston, Massachusetts, on October 21, 22, and 23. In addition to the many individual papers presented,

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there were panel discussions on Chronic Ulcerative Colitis, Diseases of the Esophagus, Peptic Ulcer and the Management of Massive Gastrointestinal Hemorrhage in Patients with Liver Disease.

On October 24, 25 and 26, immediately following the Convention, Dr. Owen H. Wangensteen, Minneapolis, Minnesota, and Dr. I. Snapper, Brooklyn, New York, were again the moderators of the Annual Course in Postgraduate Gastroenterology, held at The Somerset and in the Joslin Auditorium of the New England Deaconess Hospital.

Honorary Fellowships were presented to Dr. Chester S. Keefer, Boston, Massachusetts, Dr. William W. Frye, New Orleans, Louisiana, Dr. Stafford L. Warren and Dr. Rafe C. Chaffin, both of Los Angeles, California.

* * *

OASI Disability Check.—The number of persons under the new amendment to the Social Security law has grown very rapidly. During August there were more than a hundred thousand disability workers who received checks under the Old Age and Survivors Insurance Disability Payment program. That was the first group to receive these benefits. The program went into effect in July and these payments are for that month.

* * *

Meetings Abroad.—The eighteenth *International Congress of Ophthalmology* will meet in Brussels September 8 to 12, 1958. Elaborate programs have been arranged, but anyone who wishes to go should make his reservations immediately in Brussels because the 1958 World's Fair will be there and the city will be crowded with visitors.

The Pan American Association of Ophthalmology, celebrating its eighteenth year with some 2,000 members representing the Western Hemisphere, will hold its Second Cruise Congress on February 1-14, 1958, on board the steamship *Queen of Bermuda.* The itinerary includes a stop of a day each at San Juan, Puerto Rico; Ciudad Trujillo, Dominican Republic; Kingston, Jamaica; Port Au Prince, Haiti; and Nassau, Bahama Islands. Elaborate meetings and reports and programs will be conducted on the cruise on board ship and with meetings in each of the cities visited. For information, address Frank H. Constantine, M.D., 30 West 59th St., New York 19, New York.

The Fifth International Congress of Internal Medicine will be held in Philadelphia on April 24-26, 1958. About 1,000 Americans and about 400 overseas physicians are expected to attend. Membership is open and those eligible are invited to make application; papers will be considered. Consult Frank W. Allan, M.D., 605 Commonwealth Ave., Boston 15, Massachusetts.

* * *

The Internal Revenue Department has issued reports showing that in the year 1953 there were 145 persons with one million dollars income. That had increased to 201 in 1954. The 1954 records are the latest available and they show that only 1.3 per cent of all taxpayers, 543,000 persons, made as much as $20,000 in 1954, but

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those people received more than 10 per cent of all income and paid nearly 25 per cent of all federal income taxes on individuals. This figure includes only taxable income. Only 3.7 per cent of all taxpayers received from $10,000 to $20,000 of income in 1954, but that group received 10 per cent of all income and paid about 12½ per cent of the federal taxes. 29 per cent of all taxpayers received from $5,000 to $10,000. They received 39 per cent of all income and paid about 35 per cent of the taxes. Stated in another way, 66 per cent of the taxpayers received less than $5,000 of income. They accumulated 41 per cent of income and paid 28 per cent of the taxes. (USNWR)

* * *

Doctor Draft.—S. S. Director Lewis B. Hershey has announced officially that doctors and dentists under age thirty-five, otherwise potential inductees in selective service, are not to be drafted. The medical draft law has been discontinued and if these particular men should happen to be on any draft board call list, they are not to be inducted. This applies to any young man holding the degree of Bachelor of Medicine, as well as M.D., D.D.S., D.M.D.

* * *

Practice of Medicine by Hospitals.—The internal revenue bulletin for August 26 reports some peculiar rulings on the practice of medicine by hospitals. A non-doctor anesthetist served two hospitals, one on a salary basis and the other on a fee basis. The Internal Revenue Service held that services to the hospital are as an independent contractor rather than an employe, because working conditions are not those of the usual employer-employe relationship. Further, the ruling makes it implicit that the services rendered are not medical since the anesthetist is not a physician and therefore his earnings are regarded as the product of a trade rather than a profession for tax purposes. In another ruling, it was held that an anesthetist who works exclusively for one dental surgeon on a fulltime basis is an employe of that dentist, even though his sole remuneration consists of charges listed separately on the dentist's billings (WRNS).

* * *

Hospital Construction, Hill-Burton.—Up to July 31, 1957, the Hill-Burton program embraced 3,535 approved projects, with a total estimated cost of $2,890,497,651, the federal share of which was $908,689,102. These have added or will add more than 153,000 beds to the 898 health units. Two thirds of the projects are completed and in operation nearly 1,000 others are in various stages of construction (WRMS).

* * *

Clarence L. Candler Honored.—*The Detroit News* for Sunday, July 28, 1957, carried a picture of Dr. Clarence L. Candler, Detroit, and a story of his retirement from the practice of medicine in which he has been very active for many years, including service as a delegate to the Michigan State Medical Society and a visitor to the AMA meetings. Dr. Candler had practiced for more than forty years, had served as President of the Detroit

Board of Health, and had also been a police surgeon (at least he had a red flasher on top of his car to facilitate early arrival when calls came for help). The doctor hopes to devote more time to his private movies and "do-it-yourself."

* * *

Standing Orders for Nurses in a Mass Disaster.—The Detroit Department of Health, the Medical and Public Health Divisions of Civil Defense, and The Wayne County Medical Society have adopted a schedule of standing orders for use of nurses in mass disaster in the absence of a doctor, or before he arrives; also a formula to care for the victim patient. The Co-ordinating Committee of the Michigan State Medical Society has approved the same rules for use anywhere in the state. These rules have been revised as of February 1, 1957, and are published by the Detroit Department of Health. These rules are primarily for use when the nurse must act in the absence of a physician. Three headings are mentioned: (1) Immediate Treatment because of massive hemorrhage, asphyxia, chest wounds, abdominal wounds, burns, crash injuries, and head and spine injuries; (2) identification—an emergency medical tag; and (3) relief of pain, including a list of doses for numerous drugs. Formulae are given for various solutions and preparations needed. Detailed instructions for fracture splints are given briefly. Respiratory obstruction from whatever cause requires immediate relief. The list of standing orders occupies six single-spaced pages.

Loan Fund.—Early this year the Michigan Chapter of the American College of Surgeons established a loan fund for use of residents in surgical training who find themselves in financial difficulties. Applicants for the fund are given a careful screening, and the money is loaned free of interest, but with the understanding it will be repaid to the fund as soon as the recipient is established in practice. To date, three loans have been made. It is hoped the fund will be self-perpetuating. This is a very worthy cause, and the experience within a very few months of establishment proves the need. We congratulate the College.

* * *

J. M. Rawlings, M.D., of Flint, has been elected a member of the Royal Society of Health of London, England. The election was based on a paper delivered by Doctor Rawlings, in Rome, on "Bio-Chemical Changes of the Body Found in Pulmonary Tuberculosis."

* * *

A Fourth Bahamas Medical Conference will be held at Fort Mantagu Beach Hotel, Nassau, December 1-15, 1957. For information, write B. L. Frand, M.D., 1290 Pine Avenue West, Montreal, Canada.

* * *

The American Medical Association is concentrating its activities on the fall campaigns for funds to help our medical colleges. Committees are being formed, and

information will be coming from Chicago early in the fall.

* * *

Steven J. Figiel, M.D., Leo S. Figiel, M.D., and **D. K. Rush, M.D.,** presented a paper at the annual meeting of the American Medical Association in New York dealing with "A New Approach to the Colon Study—High Kilovoltage Spot Compression Technique."

* * *

Leo S. Figiel, M.D., and **Steven J. Figiel, M.D.,** presented a paper and exhibit at the annual meeting of the Rocky Mountain Radiologic Society in Denver, Colorado, dealing with "Unusual Manifestations of Ileo-Cecal Pathology Including the Appendix."

* * *

Medical Conferences.—The American Medical Association through its various Councils and activities is sponsoring several fall conferences of direct interest to the Medical Profession: *A National Conference of Physicians and Schools,* October 30 to November 2, 1957, at the Moraine-on-the-Lake hotel, Highland Park, Illinois, will feature "A Decade of Progress in Fitness" at its sixth session. It is sponsored by the AMA's Bureau of Health Education and will emphasize continuing interest in the health and all-around fitness of children and youth. More than eighty nationally recognized consultants have been scheduled from medicine, education and public health to lead the discussion groups.

Broadcasters and Doctors.—A two-day meeting is scheduled by the American Medical Association and the National Association of Radio and Television Broadcasters for November 7 and 8 at the Hotel Sheraton-Blackstone in Chicago, for a conference on utilization of local radio and television time by medical and health organizations. Public interest programs involving medical subjects are appearing more and more frequently. Both broadcasters and physicians want to be sure that such programs are interesting, informative and factual. The fall conference will be open to radio and television broadcasters, representatives of medical societies, hospital organizations, voluntary health organizations, and others interested in public health programs.

Rural Health.—The AMA's second study conference on October 4-5, 1957, for chairmen and members of Rural Health committees, sponsored by the Council on Rural Health, was held at Purdue University, Lafayette, Indiana. The opening session was devoted to organizational techniques of statewide Rural Health Committees. Another session featured representatives of leading farm organizations outlining their problems.

SMJAB.—The State Medical Journal Advertising Bureau, formerly sponsored by the AMA, now an independent organization of editors and business managers (M.D.) of most of the state medical society journals, will hold its annual session in Chicago, October 28 and 29, 1957. These meetings date from 1910, at Chicago.

"Study Abroad" will be the theme of the third world tour, postgraduate clinical course, sponsored by the International College of Surgeons. The professional trip, leaving San Francisco, October 20, will circle the globe in forty-eight days. The return to New York will be December 7, with optional return routings to permit stop-over privileges in many European cities. Luxury air lines will be used to cover a wide territory in a reasonably short time. Families and friends will be accommodated.

Fellows of the International College of Surgeons have arranged lectures, clinical demonstrations and entertainment in Hong Kong, the Philippines, Thailand, India, Turkey and Greece. Dr. Arnold Jackson of Madison, Wisconsin, past president of the United States Section, I.C.S., will be the co-ordinator. Detailed information may be obtained from the International Travel Service, Inc., Palmer House, Chicago.

* * *

Dr. M. Duane Sommerness, Medical Superintendent at the State Hospital at Traverse City, Michigan, announces the appointment of **Dr. F. T. Sorum** to the medical staff of that institution. Dr. Sorum received his medical degree from Rush Medical School of the University of Chicago, and since 1952 has been a member of the staff at Willmar State Hospital, Willmar, Minnesota. Dr. Sorum is a member of the South West Medical Society of Minnesota, a member of the State Medical Association, and the American Medical Association. Doctor and Mrs. Sorum with their two children, Solveg Ann and Rolph Edward, moved to Traverse City on September 1.

The Institute of Industrial Health at the College of Medicine of the University of Cincinnati announces a three-day Symposium on Fluorides to be presented December 9-11, 1957, inclusive. The purpose of this symposium will be to present the most recent information that is available concerning the physiological behavior of the absorption of fluoride.

The symposium will be open to physicians and dentists in industry and public health and to other professional persons who are interested in the subject. Attendance will be limited and early application is suggested. The registration fee will be $50.

For further information and application blank, write to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio.

* * *

The Michigan Proctological Society officers for the year are: Joseph W. Becker, M.D., Detroit, President; Donald J. Pearson, M.D., Battle Creek, President-Elect; Guy W. DeBoer, M.D., Grand Rapids, Secretary; Martin C. Sharp, M.D., Saginaw, Treasurer.

* * *

The Sister Elizabeth Kenny Foundation announces a continuance of its post-doctoral scholarships to promote work in the field of neuromuscular diseases. These scholarships are designed for scientists at or near the end of their fellowship training in either basic or clinical fields concerned with the broad problem of neuromuscular diseases.

Kenny Foundation Scholars will be appointed annually. Each grant provides a stipend of from $5000 to $7000 a year for a five-year period, depending upon the Scholar's qualifications. Candidates from medical schools in the United States and Canada are eligible.

Inquiries concerning details should be sent without delay to: Dr. E. J. Huenekens, Medical Director, Sister Elizabeth Kenny Foundation, 2400 Foshay Tower, Minneapolis 2, Minnesota.

* * *

Coccidioidomycosis, which was known up to a decade ago mainly to physicians and mycologists working in the endemic area, must now be seriously considered in the differential diagnosis of chronic pulmonary lesions in nonendemic areas. Because of the great numbers of military personnel who were stationed in endemic areas during and after World War II, a widespread scattering of the disease occurred, although the area itself apparently showed no signs of expanding.—DENIS J. O'LEARY, M.D., and FRANCIS J. CURRY, M.D., *American Review of Tuberculosis,* April, 1956.

* * *

Harold F. Diehl, M.D., Dean of the College of Medical Sciences, University of Minnesota, and long active in committee work of the American Medical Association, will assume his duties as Senior Vice President for Research and Medical Affairs and Deputy Executive Vice President of the American Cancer Society, on November 1, 1957.

Doctor Diehl is well known for his work with the AMA Council on Civil Defense, having been a member since its creation by the 1947 House of Delegates, and Chairman since December, 1954.

Congratulations, Doctor Diehl!

* * *

William A. Hyland, M.D., of Grand Rapids, Chairman of the AMA House of Delegates Committee to study the Heller Report, has called a number of meetings in Chicago beginning with one at the AMA headquarters on August 8. Doctor Hyland has invited all who have read the Heller Report and who care to make suggestions, to write to him at 110 Fulton Street East, Grand Rapids, Michigan.

* * *

Osborne A. Brines, M.D., of Detroit, has been elected, for a three-year term, as President of the International Society of Clinical Pathology.

Congratulations, Doctor Brines!

* * *

"Standing Orders for Nurses in a Mass Disaster," as approved by the Wayne County Medical Society, and developed by the Detroit Department of Health (revised on February 1, 1957) were approved by The Council of the Michigan State Medical Society on July 12, 1957.

A copy of this informative brochure is available by writing the Medical and Public Health Division of Civil Defense, Detroit Department of Health, City-County Building, Detroit 26, Michigan.

(Continued on Page (1330)

(Continued from Page 1328)

FIVE WAYS TO MAKE YOUR JOB GROW:

1. *Spend plenty of time on preliminary planning.* Planning is deciding what you want to do, when you want to do it and how you intend to do it. Time spent on planning will prove the most profitable time you spend on the job.

2. *Run your job, instead of letting your job run you, by handling details efficiently.* Don't let yourself be constantly burdened by an accumulation of unfinished jobs—things you intend to do "just as soon as you have a minute's spare time." **Do the disagreeable jobs first—the others are easy.** No job is as hard to do as it looks—it's easy once you START it.

3. *Be persistent.* Persistence is a more potent factor in getting things done than mental brilliance.

4. *Don't ever stop learning.* Try to develop the inquisitive type of mentality. Human beings are capable of adding to their accumulated knowledge as long as they live.

5. *Don't waste time thinking up alibis.* Some wise man has said that there are two kinds of people: those who use alibis and those who get things done. Instead of alibis, which look to the past, spend your time on constructive planning for the future. (From—The Office).—*ASTA News Summary,* 1957.

* * *

The man who rows the boat generally doesn't have time to rock it.

—Anonymous

The Third Annual Mercy Hospital Clinic Day will be held October 17, 1957, at Mercy Hospital Auditorium, Port Huron. A buffet luncheon will be served at 1:30 p.m.

The program by members of the Medical Staff, Grace Hospital, Detroit, Michigan, will include the following:

"The Detection and Management of Cardiac Disease in Pregnancy"—GEORGE S. FISHER, M.D., F.A.C.P.

"The Rehabilitation and Employment of the Patient with Cardiac Disease"—JOHN G. BIELAWSKI, M.D., F.A.C.P.

"The Patient with Cardiac Disease As A Surgical Risk"—DANIEL W. MYERS, M.D., F.A.C.P.

Dinner will be served at St. Clair Inn, St. Clair, Michigan, at 7 P.M. The speaker will be THE HONORABLE ROBERT J. MCINTOSH, U. S. Representative 7th Congressional District.

* * *

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, announces a postgraduate course in "Hematology" at the Institute Headquarters, 2020 East 93rd Street, Cleveland, Ohio, October 23-24, 1957. A symposium on Clinical Chemistry sponsored by the American Association of Clinical Chemists, Cleveland Section, will also be held at the Institute Headquarters, November 13-14-15. For information, write the director at the above address.

* * *

Michigan Blue Cross-Blue Shield were named winners of the top trophy for their 1956-57 Public Relations

Program. The award was made at the annual Blue Cross-Blue Shield Public Relations Institute, held in Madison, Wisconsin, August 15. The Michigan BC-BS entry—one of fifty submitted by the eighty-six clans in the United States, was selected Grand Winner on the basis of its "Systematic Realization of Planned Objectives."

* * *

The Academy of Psychosomatic Medicine will hold its fourth annual meeting at the Morrison Hotel, Chicago, October 17-18-19. For program, write William S. Kroger, M.D., Chairman, 104 S. Michigan Avenue (Suite 415), Chicago 3, Illinois.

* * *

The Milwaukee Academy of Medicine announces a Symposium on Radioisotopes, to be held at Marquette University (Brooks Memorial Union), Saturday, December 7, 1957. For program and information, write Joseph F. Kuzma, M.D., 561 North Fifteenth Street, Milwaukee, Wisconsin.

* * *

Retirement point credits may be earned by reserve officers of the Military Medical Services attending sessions of the 64th annual convention of the Association of Military Surgeons of the United States to be held in Washington, D. C., October 28 to 30, 1957, the office of the Surgeon General has announced. This applies to eligible reserve officers of each component of the medical services of the army, navy and air force.

M.D. LOCATIONS

Through September 1, 1957

Placed by Michigan Health Council

Royal Hames, M.D. ..... Lansing
Robert Kamp, M.D. ..... Beulah
James P. Capo, M.D. ..... Sunshine Hosp., Grand Rapids

Assisted by Michigan Health Council

Morton J. Kripke, M.D. ..... Berkley
D. Bonta Hiscoe, M.D. ..... Lansing
James E. Kelly, M.D. ..... Flint
Robert Huebner, M.D. ..... Hastings
James G. Hopkins, M.D. ..... Muskegon
Clarence H. Schultz, M.D. ..... Dearborn
John O. L. Jui, M.D. ..... Grand Rapids
Alfred Touma, M.D. ..... Royal Oak
Victor Glikman, M.D. ..... Pontiac
David Schane, M.D. ..... Detroit
John L. London, M.D. ..... Lakeview
Ralph Woodbury, M.D. ..... Gross Pointe

MEDICAL TELEVISION SHOWS

Produced by Michigan Health Council

WJBK-TV, DETROIT

August 4—Alcoholism—(Film—"Alcoholism the Revolving Door")
August 11—M.D. Qualities—(Film—"Even for One")
August 18—Mental Health—(Film—"Roots of Happiness")
August 25—Rehabilitation—(Film—"Man in the Window")

Communication

Dear Dr. Haughey:

Congratulations on the new cover design—"Michigan" is now visible from a distance of well over my presently receding presbyopic minimum. I like it fine.

I also liked the meaty section on medical care plans, and I wonder if a dozen copies or so might be obtained for our use here. Are over-run pages or tear sheets available?

I'm just home one day from a 9,000-mile cross-country tour with Mrs. Arnold and our fourteen-year-old son—it took us eight weeks, ever since the AMA meeting. We settled for a week between Mullet Lake and Mackinac, and again on a dude ranch in Jackson Hole, but the rest of the time we were on the move pretty steadily. Nothing like a road map to warn you that bifocals are just around the corner!

I hope to see you in Chicago in October, if I can get away.

Cordially yours,
HARRY L. ARNOLD, JR.

Honululu 14, Hawaii
(formerly, Owosso, Michigan)
July 30, 1957

Dear Doctor Haughey:

The JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, Vol. 56, No. 7, for July, 1957, contains an editorial captioned, What Is A Hospital? over the name of Dr. Clarence I. Owen. This has been drawn to my attention because of the deep interests of the staff of one of our research projects in arriving at such a definition. The first article on this subject has been published in *Hospitals*, the journal of the American Hospital Association, under the title "Sense or Jabberwocky?" This first article appeared in issue No. 12 of Vol. 31, published under date of June 16, 1957. We anticipate that the first set of definitions, including those for hospitals in certain broad categories, will be published in the near future.

I should like to make it clear that our definitions are the product of research activity conducted under the sponsorship of the American Hospital Association, but otherwise independent of Association direction or policy. The Association may later choose to adopt definitions we have arrived at if they stand the test of scrutiny to which they are sure to be subjected. The research program is carried on under grant from the Bureau of Medical Services of the U. S. Public Health Service through its National Advisory Hospital Council. The definitions work is one phase of a total project devoted to determination of "The Future Needs for Hospital Facilities."

I would like to express sympathetic understanding of Doctor Owen's viewpoint as expressed in this editorial. Teamwork of a high order between those who bear responsibility for the administrative and professional activities within hospitals is essential in this as in all other operations of mutual concern. We look forward to considerate reflection on our labors by the medical profession in all its component parts when our definitions are published. Dr. Owen may wish to watch for this output of our staff.

Sincerely yours,
ALAN E. TRELOAR, Ph.D.
Director of Research

Chicago, Illinois
August 22, 1957

To The Editor
Dear Sir:

Upon reading my good friend Foster's contribution to the symposium on Michigan Medical Service, in the June issue of the JOURNAL, I am compelled to contribute a few items to the historical account. I agree that the younger members of the profession should be informed about its birth. It is a legitimate one.

My interest is also legitimate, due to the fact that I am one of the two living members of the original committee that started the whole thing. The other is Dr. Greg. Christian of Lansing.

The committee in question, as you will remember, was known as The Marshall Committee. It was appointed by the then President, Dr. Carl Moll of Flint, and consisted of Dr. William Marshall, Flint, Chairman; Dr. Frederick A. Baker, Pontiac; Dr. L. G. Christian, Lansing; Dr. B. U. Estabrook, Detroit; Dr. C. S. Gorsline, Battle Creek. Dr. F. C. Warnshuis, then secretary of the State Society, acted as an *ex officio* member.

We presented the first insurance plan, mutual health service, back in 1933, when the phrase, health insurance, was a dirty word. Those were the days of the great depression, days of fear. Federal government was upsetting our old concepts. The social revolution was on. Compulsory health insurance was being widely urged by powerful lay groups.

We were ahead of the times with our proposal. The profession, not only in Michigan, was afraid of insurance medicine. The AMA strenuously opposed it. Our House of Delegates refused to accept even the principle of insurance.

Today, all this sounds funny. I can assure you that it was not funny then!

I would add this. There is much to be done. I trust that those in charge continue to have the vision and courage necessary for making Michigan Medical Service better. To quote Sir Arthur Salter, "It is our system in which we have grown up that we must reform—and in part transform."

Most sincerely yours,
FREDERICK A. BAKER

Pontiac, Michigan
August 12, 1957

Dear Mr. Burns:

Previously, we have written to you and asked your co-operation on this same subject. We appreciate your consideration and thank you sincerely for your past help.

The following paragraph is from our contract, V1005 M76, with the Veterans Administration:

"USP and NF PRODUCTS—The Contractor, without cost to the Veterans Administration, will from time to time, and by appropriate means, advise the Michigan State Medical and Dental Societies of the availability of *USP* and *NF* Products in an effort to establish prescribing practice which will permit the dispensing of the highest quality drugs for beneficiaries of the Veterans Administration at the lowest possible cost to the Veterans Administration."

Following the details of this paragraph, we submit for your review and counsel, the enclosed items. When time and space permits, would you pass this information on to your members.

Each licensed pharmacy in Michigan has in his extensive library, an up-to-date copy of the United States Pharmacopeia and National Formulary.

These publications are available to the members of the Medical and Dental Societies either for use in the store or for reference work in the office.

Sending my best personal regards and again, our ap-

preciation for your many favors extended our association and this office.

Cordially,
JOHN H. BUTTS
Executive Secretary

Lansing, Michigan
August 21, 1957

Three Bromides Tablets, National Formulary
Category—Central depressant.
Usual Dosage Each of Ammonium Bromide, Potassium Bromide, and Sodium Bromide—300 mg. (approximately 5 grains).
Three Bromides Elixir, National Formulary
Category—Central depressant.
Usual Dose—4 ml. (approximately 1 fluidram).
One usual metric dose contains about 320 mg. each of Ammonium Bromide, Potassium Bromide, and Sodium Bromide.
Compound Resorcinol Ointment, National Formulary
Category—Local irritant; antibacterial; antifungal.
Zinc Oxide Paste with Salicylic Acid, National Formulary
Category—Astringent; protective.
Compound White Pine Syrup with Codeine, National Formulary
Category—Antitussive.
Usual Dose—4 ml. (approximately 1 fluidram).
One usual metric dose contains 8 mg. of Codeine Phosphate.
Thymol Iodide, National Formulary
Category—Antifungal; anti-infective.
Thimerosal Ointment, National Formulary
Category—Antibacterial.
Ichthammol Ointment, National Formulary
Category—Local antibacterial; irritant.
Ascorbic Acid Tablets, The Pharmacopeia of the United States (The United States Pharmacopeia) 15th Revision
Category—Antiscorbutic vitamin.
Dose—Daily, oral and subcutaneous.
Usual—Requirement, 75 mg.
Therapeutic, 150 mg.
Range—Requirement, 25 to 75 mg.
Therapeutic, 100 mg. to 1 Gm.
Cortisone Acetate Tablets, The Pharmacopeia of the United States (The United States Pharmacopeia) 15th Revision
Category—Adrenocortical hormone.
Dose—Usual—Oral, 25 mg. four times a day.
Intramuscular, 100 mg. daily.
Range—Oral, 2.5 to 75 mg.
Intramuscular, 5 to 300 mg.
Phenobarbital Elixir, The Pharmacopeia of the United States (The United States Pharmacopeia) 15th Revision
Category—Central depressant.
Dose—Usual—5 ml. (20 mg. of phenobarbital) four times a day.
Range—5 to 15 ml.
Atropine Sulfate Tablets, The Pharmacopeia of the United States (The United States Pharmacopeia) 15th Revision
Category—Parasympatholytic.
Dose—Usual—0.5: topically as 1 to 2 per cent solution.
Range—0.3 to 1.2 mg.
Belladonna Tincture, The Pharmacopeia of the United States (The United States Pharmacopeia) 15th Revision
Category—Parasympatholytic.
Dose—Usual—0.6 ml. three times a day.
Range—0.3 to 2.4 ml.
Clove Oil, The Pharmacopeia of the United States (The United States Pharmacopeia) 15th Revision
Category—Dental obtundant: pharmaceutic necessity for Diphenhydramine Hydrochloride Elixir.
For External Use—Topically as required.
Isoniazid Tablets, The Pharmacopeia of the United States (The United States Pharmacopeia) 15th Revision
Category—Tuberculostatic antibacterial.
Dose—Usual—100 mg. twice a day.
Range—50 to 200 mg.

Achievements after Sixty.—When you look at the facts, a man's best days are not over at sixty. There are figures to show that the greatest achievements of man were consummated between his sixtieth and seventieth year.

Examining the histories of some 400 career men, the most notable and outstanding statesmen, painters, warriors, poets and writers of their times, indicates the decade of years between sixty and seventy contained 35 per cent of the world's greatest achievements; between seventy and eighty years, 23 per cent; after eighty years, 8 per cent. In other words, 66 per cent of all great achievements accomplished by man were developed and given posterity after he had reached or passed his sixtieth year.—*Midland Rotary Table.*

THE DOCTOR'S LIBRARY

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

CHRONIC ILLNESS IN THE UNITED STATES. Volume I. Prevention of Chronic Illness. Commission on Chronic Illness. Published for the Commonwealth Fund. Cambridge, Massachusetts: Harvard University Press, 1957.

The Commission on Chronic Illness is publishing four volumes on Chronic Illness. This is the first, and is the result of seven years' study and investigation by the voluntary commission composed of representatives of many national societies—Cancer, Heart, Dental, Hospital, Medical, Psychiatric, Public Health, Public Welfare, Rheumatism, Muscular Dystrophy, Polio, Multiple Sclerosis, Tuberculosis, Crippled Children, and Health Insurance, or various Foundations.

During the years, many reports have been issued, but the work is now being summarized in four very presentable volumes from the Harvard University Press.

The introductory part is explanatory. The first section of the book is devoted to the problems of Prevention, Promotion of Health, Primary Studies, Periodic Health Examinations, Screening, Education and Planning. Chapters are devoted to the list of chronic diseases, represented largely by the national societies associated in the commission—Arthritis and Rheumatism, Blindness, Cancer, Cardiovascular Disease, Cerebral Palsy, Diabetes, Epilepsy, Deafness, Mental Health, Multiple Sclerosis, Poliomyelitis, Late Syphilis, Tuberculosis, Chronic Industrial Disease, Dental Health, Emotional Factors, Heredity, Malnutrition and Obesity. These chapters are very well written, giving valuable information and procedures found to be applicable.

The final part of the book is devoted to appendices on History of the Commission, By-Laws, list of publications. Appendix E lists the largely controllable chronic diseases, the partially controllable, and the uncontrollable ones.

WILLIAM HARVEY. His Life and Times: His Discoveries: His Methods. By Louis Chauvois. Foreword by Sir Zachary Cope. New York: Philosophical Library, 1957. Price, $7.50.

This is a very well-written and well-translated biography of one of the giants in the medical world, prepared for the tercentenial of his death, which occurred June 3, 1657. The treatment is unusual. A day in Dr. Harvey's life is given in detail, and the day selected was when he was forty-nine years of age, just before publishing his theory of the circulation of the blood. The concept had been announced and used by him and some of his friends for ten years, but had not been published publically. The story is given of his being summoned to the bedside of King Charles I, who was very ill with

pneumonia. Description is made of treatment and use of leeches by the doctor himself.

Chapters are given to the early days of study and services in hospitals, his war service, and his later years when he had become famous and wealthy—at least he had constructed a building at the medical school to contain his office and teaching facilities. The doctor's death scene is given, his will and the disposition of his effects, including the withholding from one heir of his coffee pot, which went to his younger brother, his executor. About a third of the book is devoted to an appreciation of Dr. Harvey's life and work, of which the discovery of the circulation of the blood was the most outstanding of all medical history. His work as a renowned surgeon, anatomist and medical writer are well presented. He made many of his own illustrations. We are happy to add this volume to an increasing list of biographies of medical greats.

SURGEONS ALL. By Harvey Graham, M.D. Foreward by Oliver St. John Gogarty. New York: Philosophical Library. Price $10.00.

This book gives a rather comprehensive study of the history of surgery. In covering the development of the art through the ages, the book travels about, relating interesting and historical deeds. The book is well written and the narrative style keeps one's interest at a high level. This book is proof that the history of medicine provides extremely interesting reading.

R.L.M.

AN ATLAS OF THE COMMONER SKIN DISEASES. With 153 Plates reproduced by direct color photography from the living subject. By Henry C. G. Semon, M.A., D.M. Oxon., F.R.C.P. London; Consulting Physician for Diseases of the Skin, and former Lecturer to Postgraduates, Royal Northern Hospital; Consulting Dermatologist, Hampstead and North-West London General Hospital; Ex-president and Vice President, Dermatological Section, Royal Society of Medicine; Corresponding Member of the Societe Francaise de Dermatologie at Syphilologie; Medaille d'Honneur de l'Assistance Publique, Republique Francaise; Medical Referee for Industrial Dermatitis, Ministry of National Insurance. Revised with the collaboration of Harold T. H. Wilson, M.A., M.D., Cantab., M.R.C.P., D.T.M., Dermatologist and Lecturer to Postgraduates, Royal Northern and Central Middlesex Hospitals; Dermatologist, Mount Vernon Hospital, Northwood, Wimbledon, and Highlands Hospitals. Color photography originally directed by the late Arnold Moritz, B.A., M.B., B.C. Cantab. Fifth edition. Baltimore: The Williams and Wilkins Company, 1957. Price, $20.00.

This book contains a full-page color photograph along with a brief discussion of 131 of the commoner skin diseases and twenty-two more of the less common skin diseases. For the most part, the photographs represent well the topic under discussion, and the color reproduction is excellent. The authors live in Great Britain, but their text is very close to that of American authors. For a general physician who wants a quick reference along with good color pictures to aid him in his dermatological problems, this is an excellent atlas.

FOOT TROUBLES. By T. T. Etamm, F.R.C.S. New York: Philosophical Library, Inc., 1957. Price, $4.75.

This book of 122 pages was printed in England on white non-gloss paper with large easily readable type, is hand size and completely acceptable. The text is divided into ten chapters dealing with the foot and its mechanics, its diseases of improper function, deformities and their correction, infections, injuries, pain and effects of chronic diseases. The care of the foot in health, and in certain diseases as diabetes which possess certain special liabilities. Care of children's feet and footwear are given proper attention, and the problem of selection of shoes is studied. There are illustrations and diagrams. The book is very readable and will be of great assistance in many lines.

CIBA FOUNDATION COLLOQUIA ON AGEING. Volume 3. Methodology of the Study of Ageing. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, BSc. 47 illus. Boston: Little, Brown and Company, 1957. Price, $6.50.

The Ciba Foundation is continuing its plan of conferences on various medical subjects. The Foundation invites to London, England, leaders in kindred subjects who attend, present their reports of papers, and enter into discussions. The material is then edited and published in book form. This number is the third volume on The Colloquia on Ageing: Methodology of the Study. Twenty-eight scientists from the entire world assembled and took part; five from the United States and three from Canada, with Charles H. Best, M.D., of Toronto, acting as chairman. The thirteen papers were presented with their discussions, a very creditable array of talent. This book is just as interesting as its predecessors.

DERMATOLOGIC FORMULARY. From the New York Skin and Cancer Unit, Service of Dermatology (Dr. Marion B. Sulzberger, Director). Frances Pascher, M.D., Editor. Revised, 1957. New York: A Hoeber-Harper Book, 1957.

This is a most complete dermatologic formulary listing a multitude of preparations with a brief discussion of the items together with their uses, indications and contraindications. It is right up to date with listings of drugs which have been on the market only a few months. This is an excellent booklet and highly recommended for the general physician or beginning dermatologist.

H.A.

THE POWER OF SELF-KNOWLEDGE. Body and Mind Awareness; A New Technique For Successful Living. By Milton W. White, M.D. A dynamic, practical learning-method to help you understand and control your own emotions, thinking, and behavior in order to achieve maximum health, happiness, and self-acceptance. New York: The Julian Press, Inc., 1957. Price $3.95.

This book, written by one of our members in Detroit, is primarily designed for use of patients with psychosomatic problems. General semantics are called upon to

outline self-knowledge, case histories being cited as a help. The second part, "How to protect yourself from the fear based emotions," is philosophical and covers nervousness, hostility, frustration, guilt, shame, and remorse. Proper and suggested co-ordination and willingness can wipe out such emotions and their self-stimulated disease conditions. The third section of the book is divided into five sections, showing how self-knowledge can give a life of health, happiness and self-satisfaction. This is especially a book for the patient whose troubles may be mostly self-induced.

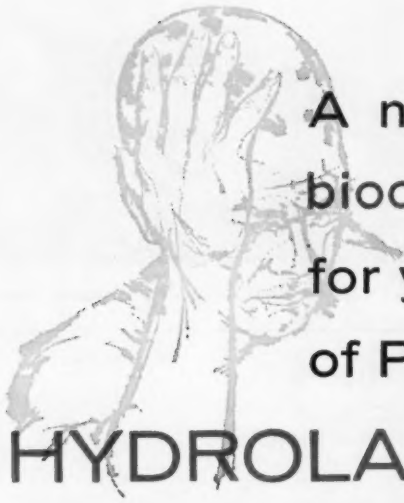
THE SURGICAL MANAGEMENT OF PULMONARY TUBERCULOSIS. Edited by John D. Steele, M.D. Introduction by Frederick A. Coller, M.D. Biographical Sketch of John Alexander by Cameron Haight, M.D. Springfield, Illinois: Charles C Thomas. Price $9.50.

In this first volume of a planned John Alexander Monograph Series, fourteen thoracic surgeons trained by Dr. Alexander have collaborated to produce a fine résumé of the current surgical treatment of all phases of pulmonary tuberculosis. The final chapter on the chemotherapy of tuberculosis, was written by his medical colleague, John B. Barnwell. John Steele has reviewed the evolution of the surgery of pulmonary tuberculosis, summed up the modern thoracoplasty technique, and has commented on changes in this field since the 1925 and 1937 textbooks published by Dr. Alexander (who was working on a revised edition of "The Collapse Therapy of Pulmonary Tuberculosis" at the time of his death in 1954).

Pulmonary resection for tuberculosis with pneumonectomy and segmental resection is discussed with slightly varying viewpoints by several surgeons. Other authors (in separate chapters) cover combined collapse and resection therapy, thoracoplasty, extraperiosteal plombage, treatment of pleural tuberculosis, decortication, cavernostomy and the surgical management of pulmonary tuberculosis in psychotic patients. These discussions are nicely illustrated with x-rays and anatomical drawings. This book is very well done and will be an excellent reference textbook for physicians and surgeons in this field.

S.B.W.

Index to Advertisers



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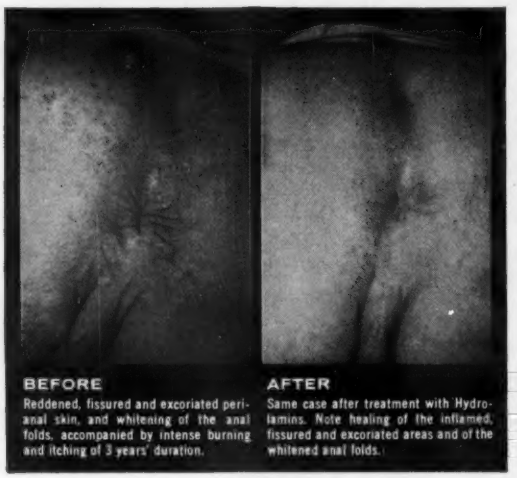


BEFORE
Reddened, fissured and excoriated perianal skin, and whitening of the anal folds, accompanied by intense burning and itching of 3 years' duration.

AFTER
Same case after treatment with Hydrolamins. Note healing of the inflamed, fissured and excoriated areas and of the whitened anal folds.

98% Effective[1] and Why —
Recent observations on the pruritogenic effects of proteolytic enzymes[2] have focused new interest on the value of proteins and amino acids in pruritus ani.

Using selected amino acids—Hydrolamins—Bodkin and Ferguson[1] obtained relief in 98% of pruritus ani cases. McGivney[3] states that practically all his patients have had immediate relief.

Hydrolamins offers a *protective* stainless biochemical barrier to irritating enzymes and also *neutralizes* alkaline irritants seeping from the anal canal.

100% Safe and Why —
Being biochemical in character and having a pH of around 6, Hydrolamins harmonizes with the skin, does not—unlike the "caines" and steroids—tend to cause treatment dermatitis or sensitization—in a word is SAFE.

Hydrolamins is, therefore, indicated in the topical treatment of—

Pruritus Ani et Vulvae • Fissures • Diaper Rash • Anal Irritations and Erythemas • Pinworm Pruritus • Ileostomy and Colostomy Irritations

SUPPLIED: 1 oz. and 2.5 oz. tubes.

Lewal *Pharmaceutical Company* • *Chicago 14, Illinois*

1. Bodkin, L. G., and Ferguson, E. A., Jr.: Am. J. Digest. Dis. 18:59 (Feb.) 1951. 2. Arthur, R. P., and Shelley, W. B.: J. Invest. Derm. 25:341 (Nov.) 1955. 3. McGivney, J.: Texas J. Med. 47:770 (Nov.) 1951.

in acne

"results were uniformly encouraging"[1]

pHisoHex®

Sudsing, nonalkaline antibacterial detergent—nonirritating, hypoallergenic.

The acne skin that is "surgically clean" is the one most likely to clear completely. Hodges[1] found that standard acne treatment usually results in "mediocre success" for most patients. *The addition of pHisoHex® washings to standard treatment produced results that far excel any obtained previously.*

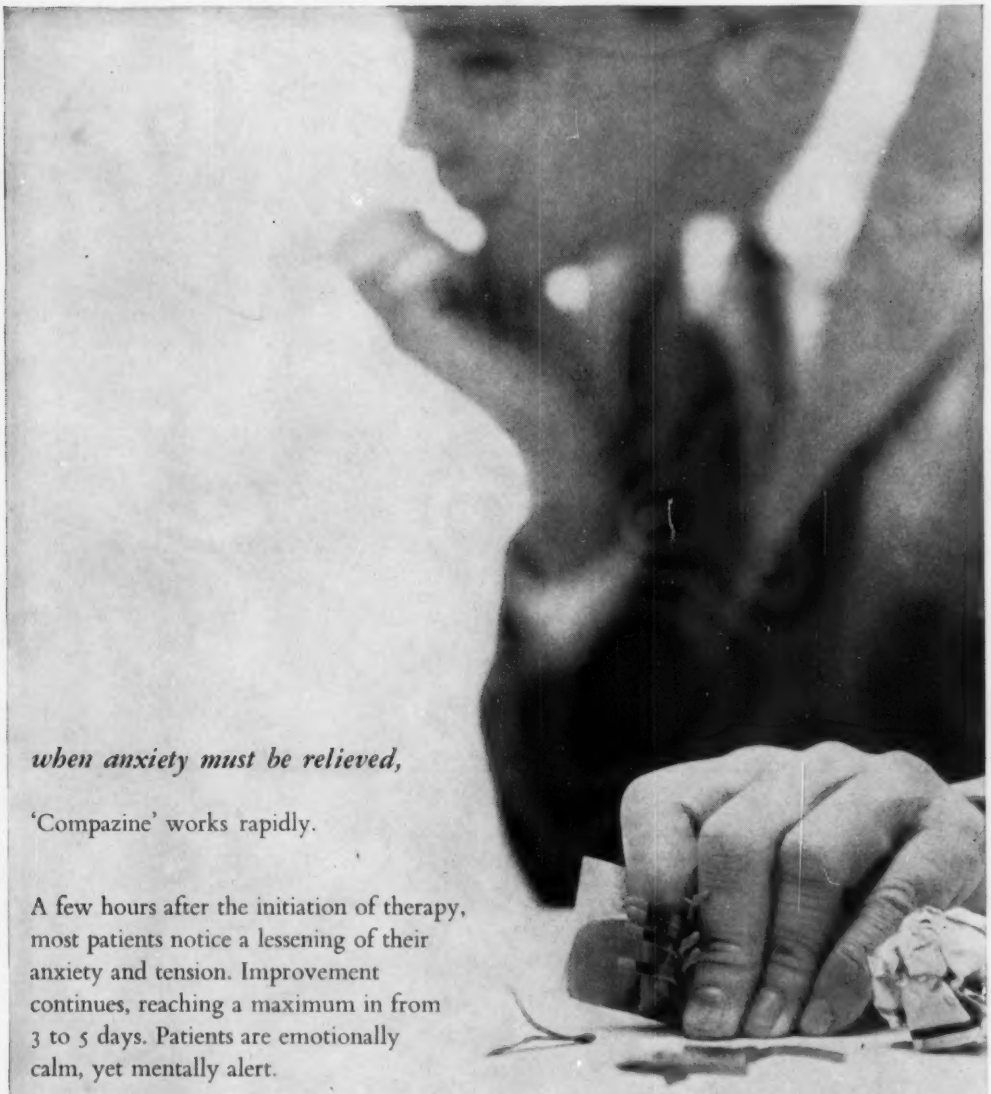
pHisoHex, a powerful antibacterial skin cleanser containing hexachlorophene, removes oil and virtually all the bacteria from the skin surface.

For best results prescribe from four to six pHisoHex washings of the acne area daily.

1. Hodges, F. T.: GP, *14*:86, Nov., 1956.

pHisoHex, trademark reg. U. S. Pat. Off.

Winthrop LABORATORIES
New York 18, N.Y.



when anxiety must be relieved,

'Compazine' works rapidly.

A few hours after the initiation of therapy, most patients notice a lessening of their anxiety and tension. Improvement continues, reaching a maximum in from 3 to 5 days. Patients are emotionally calm, yet mentally alert.

Compazine★

S.K.F.'s outstanding tranquilizer

Available:

Spansule† capsules, 10 mg. and 15 mg.
Tablets, 5 mg. and 10 mg; and, primarily for use in hospitalized psychiatric patients, 25 mg. tablets.
Ampuls, 10 mg. (2 cc.)

Smith, Kline & French Laboratories, Philadelphia

★T.M. Reg. U.S. Pat. Off. for prochlorperazine, S.K.F.
†T.M. Reg. U.S. Pat. Off. for sustained release capsules, S.K.F.
Patent Applied For